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Contraceptive Sterilisation: A History of Tubal Ligation and Vasectomy in Twentieth Century Australia, 1926-86

Tiarne Barratt

A thesis submitted in fulfilment of the requirements for the degree of Master of Philosophy

Faculty of Arts and Social Sciences
University of Sydney, 2015
Statement of Originality:

I declare that the research presented here is my own original work and has not been submitted to any other institution for the award of a degree.

Signed: [Signature]

(Tiarne Barratt)

Date: 21 February 2015
Abstract:

This thesis considers the rise of contraceptive sterilisation throughout the twentieth century, using Australia as a case study to focus consideration of this global trend. From the 1920s to the 1980s, a series of gradual social changes took place that affected understandings and practices of tubal ligation and vasectomy, which led to sterilisation achieving worldwide popularity as a contraceptive by the 1980s. This diachronic rise in popularity is explored in relation to ideas of gender, sexuality, technology, and experiences of tubal ligation and vasectomy – this is not a thesis about public discussion, instead actual practices of sterilisation are the primary focus.

The central argument of this thesis is that contraceptive sterilisation occurred throughout the twentieth century: largely removed from the public eye in the early decades, practices of tubal ligation and vasectomy began to alter in the 1950s and ‘60s – a period of rapid change that preceded the universal upswing of surgical contraception in the 1970s and ‘80s. In the twenty-first century, tubal ligation remains the most prevalent method of contraception in the world, yet sterilisation has rarely been the subject of historical analysis outside the realm of the eugenics movement. Additionally, it is often absent in histories of birth control, which are frequently dominated by the introduction of the pill and the “sexual revolution” of “the sixties”. In light of this, I argue that contraceptive sterilisation deserves considerably more scholarly attention than it currently receives and this thesis contributes to histories of birth control, sex, gender, medicine, technology and eugenics.
Preface:

This thesis consists of entirely my own research and opinions. The material used to construct this argument includes archival documents from both public and private collections; an array of published primary sources such as medical journals; oral histories obtained for the purpose of this research; and related secondary source material. Where the work of others has been used, this is appropriately acknowledged and all secondary sources are accordingly cited in the footnotes of this thesis.

The total word count for the thesis body – excluding footnotes – is 52,980. This falls into the range specified by the University of Sydney for Master of Philosophy theses of 40,000-60,000 words. No material within this thesis has been submitted elsewhere for the award of a degree.

At the outset of this research, approval was obtained from the Human Research Ethics Committee at the University of Sydney to undertake oral history interviews on the subject of ‘The Normalisation of Contraceptive Sterilisation in post-war Australia’ (Project No. 2013/534; approved 4 July 2013). Twenty interviews with doctors and patients of contraceptive sterilisation were conducted over the course of this research, which provide the bulk of primary research undertaken for the completion of this thesis. With full consent of the participants involved, some respondents are identified by name throughout, while the identity of all other participants has been protected by anonymising any identifying personal details.
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I have been extremely lucky to have had the ongoing support and motivation of my family and friends throughout this process, and for that I am endlessly thankful to them. The love, patience, and encouragement of my partner Emily has been invaluable; the understanding and friendship of Felicity has kept me sane; I thank Linda for her tireless help and support.

I am extremely grateful to all the people who volunteered to share their time and memories with me via oral history, I would not have been able to uncover this story without their help and I thank them for their extraordinary contribution to this research. In particular, Bruce Errey, Stefania Siedlecky, Barbara Simcock, and Ian Stewart, who opened their professional lives and histories to me, and shaped this thesis.

Finally I would like to thank various members of staff at the University of Melbourne Archives; the University of Sydney Medical and Fisher libraries; the State Libraries of New South Wales and Victoria; the Veech Library at the Catholic Institute of Sydney; the History of Medicine Library at the Royal Australasian College of Physicians; Family Planning New South Wales and Queensland; and the National Archives of Australia. Countless individuals assisted me with this research, often going above and beyond what was required of them.
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List of Abbreviations:

ACR – *Australasian Catholic Record*

AMA – Australian Medical Association

BEPC – Bruce Errey Private Collection

BMA – British Medical Association

BMJ – *British Medical Journal*

CHC - Combined Hormonal Contraceptives

ESV – Eugenics Society of Victoria

FPA – Family Planning Association

GP – General practitioner

IUD – Intrauterine device

MJA – *Medical Journal of Australia*

ML – Mitchell Library

NHC – Norman Haire Collection

NSV – No-scalpel Vasectomy

NSW – New South Wales

QLD – Queensland

RFH – Rachel Forster Hospital

RHA – Racial Hygiene Association [of New South Wales]

VHWC – Victor Hugo Wallace Collection

VIC – Victoria

WWC – Women’s Welfare Clinic
Introduction

Memorable for his colourful personality, radical opinions, and pioneering work in sexology, sex reform, and birth control, Norman Haire (1892-1952) is a well-known figure in Australian histories of sex and sexuality.¹ He is less known for his role as an early twentieth century practitioner of sterilisation. In 1950 Haire received a letter from a reader of the Australian Woman magazine – to which he was a regular contributor – enquiring about the contraceptive popularity of sterilisation:

Anonymous: Dear Dr. Terriss: I read your Woman article of July 4 dealing with an operation on the Fallopian tubes, to prevent pregnancy… Could you please tell me if this particular operation is popular..?

Norman Haire: I am at a loss to understand what she means when she asks if the operation is “popular”. I do not know of any surgical operation which could be described as being “popular”.²

In 1950, the “popularity” of tubal ligation was incomprehensible to Haire. However three decades later, contraceptive sterilisation had become a surgical procedure so common as to be legitimately called ‘popular’: in the 1980s tubal ligation and vasectomy represented over fifty per cent of birth control usage amongst married women in Australia – a far cry from the contraceptive landscape that Haire departed in the mid-twentieth century.³ This thesis explores the normalisation and corresponding rise in popularity of contraceptive sterilisation in Australia over the course of the twentieth century, and a focus period of

² Wykeham Terriss, ‘A Doctor Looks at Life – Surgical Sterilisation’, Woman, 9 October 1950, Box no. 2.25 (1), Norman Haire Collection, University of Sydney Rare Books Collection [hereafter NHC].
1926-86 reveals the diachronic rise of surgical contraception, that is tubal ligation and vasectomy. Unlike other popular methods of contraception such as the pill, sterilisation does not have an easily identifiable date of introduction that marks the beginning of this narrative or of its initial contraceptive application. Instead this history was characterised by a gradual acceptance and uptake of these surgical procedures. Over the course of this sixty-year period tubal ligation and vasectomy were socially, culturally, medically, and legally transformed: what were infrequent, covert operations in the 1920s and ‘30s, had by the 1980s, become the most widely used method of birth control in Australia for people over thirty-five – a popularity that was reflected throughout the world.\(^4\)

In the first half of the twentieth century, public consideration of sterilisation took on a decidedly eugenic focus, and this phenomenon has been the subject of significant scholarly attention, both in Australia and internationally.\(^5\) As a result, sterilisation has long been synonymous with eugenics, coercion, and the Nazi regime: in particular, Randall Hansen and Desmond King recently argued that the twentieth century was ‘a century of coerced sterilization’, due to the hundreds of thousands of involuntary operations that took place.\(^6\) While it would be both incorrect and offensive to deny the history of involuntary sterilisation, this is not the only side to this story and this focus on coercive and eugenic


practices has masked an underlying history of contraceptive sterilisation: when disentangled from this entrenched association with eugenics and coercion, it becomes apparent that tubal ligation and vasectomy had an equally complex and parallel history of voluntary reproductive control. For example, Hansen and King estimated that 60,000 Americans were forcibly sterilised from the 1910s to the 1970s. In comparison, over 70,000 Australians underwent contraceptive sterilisation in 1974 alone. I emphasise this not to diminish the significance of coercive sterilisation, but to quantifiably justify the importance of explaining the history of contraceptive sterilisation as well, which is the purpose of this thesis. The choice to focus on 1926-86 challenges current constructions of eugenic sterilisation, reframing sterilisation within historiographical considerations of birth control in the twentieth century.

Sterilisation has often been under public discussion, however, this thesis is not a history of a debate, but rather it is a social and medical history of actual contraceptive sterilisation practices in the twentieth century: experiences of tubal ligation and vasectomy are prioritised over public discussion of this phenomenon. A textual, archival, and oral history study of the careers of six Australian doctors shape this research – Norman Haire (1892-1952), Victor Hugo Wallace (1893-1977), Stefania Siedlecky (b.1921), Bruce Errey (b.1931), Barbara Simcock (b.1935) and Ian Stewart (b.1943). Collectively, their experience in providing either tubal ligation or vasectomy to Australian men and women spanned the 1920s to the 2000s and each was selected for study as a result of their influential contribution to the uptake of contraceptive sterilisation throughout the twentieth century.

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7 Hansen and King, *Sterilized by the State*, pp. 3-4;
8 See Figure I.1. Medibank claims data obtained by Barbara Simcock in the 1970s, in Bruce Errey Private Collection [hereafter BEPC], accessed January 2014.
9 The term contraceptive sterilisation will be used throughout this text to identify all tubal ligation and vasectomy procedures that occurred under voluntary circumstances, where the patient actively sought out permanent birth control in the form of surgical sterilisation. The ongoing association of sterilisation with coercion makes it necessary to define this terminology: in any circumstance where the author is referring to the involuntarily application of sterilisation procedures, this coercive context will be identified accordingly.
Though slight in number, their experiences are representative of the tight-knit community of doctors who orchestrated the rise of surgical contraception in Australia. In addition to doctors, patient experiences of contraceptive tubal ligation and vasectomy are analysed via oral testimonies and surviving patient records – both the Victor Hugo Wallace Archive at the University of Melbourne and Bruce Errey’s private archival collection contain valuable patient records. The Wallace archive is a popular feature in Australian histories of eugenics and female sexuality in the first half of the twentieth century, however this collection also includes over 200 vasectomy patient records of contraceptive operations performed from the 1930s-70s. The Wallace and Errey patient records offer a unique insight into the experience of surgical contraception in twentieth century Australia.

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10 Dowbiggin’s recent work on sterilisation as a global family planning initiative emphasised the impact that a small number of individuals had on this history; Dowbiggin, *The Sterilization Movement*, pp. 3-4.
Figure I.1: Figures relate to claims made through Medibank for vasectomy and tubal ligation procedures. Data collected by Dr Barbara Simcock from the Department of Social Security. Original in Bruce Errey Private Collection [BEPC], accessed January 2014.
The broader impact of contraceptive sterilisation in the latter half of the twentieth century is visible in historical contraceptive statistics.\(^{12}\) Despite inconsistencies in survey methods, this data reveals that large numbers of people increasingly relied on tubal ligation and vasectomy for permanent birth control.\(^{13}\) This data also highlights the importance of age within contraceptive choice, as sterilisation has been consistently most common amongst people aged thirty-five and over who had completed their families.\(^{14}\) This trend is most visible from the late 1960s onwards, as generations of women who had been using oral contraceptives in their early twenties began to replace the pill with sterilisation upon reaching their thirties.\(^{15}\) A 1980 survey run by *The Australian Women’s Weekly* of 30,000 readers from across the country revealed that overall, 19\% of women surveyed relied on tubal ligation or vasectomy to protect them from unwanted pregnancy. However when this was broken down by age, it was discovered that 55\% of women in the 35-44 year age bracket relied on sterilisation – a figure that was mirrored in pill usage amongst 19-24 year olds.\(^{16}\) In 1986 the Australian Family Project undertook the first large-scale national survey of contraceptive usage. This study considered the birth control habits of married

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\(^{13}\) It is difficult to compare the different sets of data available and thus compile evidence of an overall statistical trend because the demographical boundaries of historical surveys rarely align (this applies to both Australia and the world). For example, some years only married women were surveyed, others the age group was altered, and so on. However these surveys are still valuable as an indicator of general trends in the overall usage of tubal ligation and vasectomy.


\(^{16}\) ‘The Amazing Popularity of Sterilization’, pp. 29, 33.
women aged 20-49 and revealed that 38.1% of respondents were currently using contraceptive sterilisation.\textsuperscript{17} A comparable study in 1995, the Australian National Health Survey, questioned both married and single women aged 18-49, and found that with this expanded demographic, only 22.5% of respondents were currently using contraceptive sterilisation.\textsuperscript{18} Around the world, the application of contraceptive sterilisation has been influenced by geographical location, age, marital status, the technology available, and the perceived gendered responsibility of birth control. Australian contraceptive data reveals that tubal ligation has been gradually declining in popularity since the late 1980s, however rates of vasectomy have remained stable into the twenty-first century.\textsuperscript{19} The most important point to take from this data is that there was a high demand for contraceptive sterilisation, particularly in the second half of the twentieth century: the increased availability of these procedures had a significant impact on many people’s reproductive lives and sexual relationships, which makes this contraceptive trend an important subject of further historical analysis.\textsuperscript{20}

\textsuperscript{17} Contraception is now considered to be a female responsibility, therefore for the most part, this data refers to women of reproductive age, as it is believed that this group will provide the most accurate rates of use. Chief investigator of the 1986 Family Project remarked that: ‘The core of the women’s questionnaire is a collection of detailed life histories, on marital unions, childbearing and children, contraception, work history and residential mobility.’ In contrast, ‘The men’s questionnaire began with questions seeking attitudes towards sex roles within the family and towards home ownership. Other questions sought details of all marriages and cohabiting relationships and of the current divisions of labour and decision making within the home.’; M. Bracher and G. Carmichael, ‘The Australian Family Project, 1986’, Australian Data Archive – Social Science \url{https://www.ada.edu.au/social-science/browse/family-studies/the-australian-family-project--1986}, accessed 24 January 2015.


\textsuperscript{19} An increase in hormonal contraceptive options and lengthy waiting periods for non-elective surgery in public hospitals has meant that in twenty-first century Australia, tubal ligation is no longer a widely used method of contraception. In contrast, vasectomy continues to remain readily accessible and relatively inexpensive in the private sector; The State of our Public Hospitals, June 2006 Report (Canberra: Department of Health and Ageing, 2006), pp. 25-30; Christine Read et al. eds., Contraception: An Australian Clinical Practice Handbook (Canberra: Sexual Health and Family Planning Australia, 2008), pp. 67-128.

This thesis begins in the 1920s and ‘30s when contraceptive tubal ligation and vasectomy were uncommon procedures that largely went unnoticed. In the 1950s, surgical contraception first began to be publicly discussed, witnessed in its increased uptake amongst individual Australian couples, and in the prominence of international family planning programs.\textsuperscript{21} This gradual transition to public visibility continued during the “sexual revolution” of the 1960s, and by the early 1970s contraceptive sterilisation had captured international media attention. This attention was often critical of Indian sterilisation policies for example, yet in places like Australia, media attention led to an increase in public demand for contraceptive sterilisation. How and why this shift occurred will be explored through four chronological chapters with a focus on medical technology, the eugenics movement, the Catholic Church, understandings of gender – particularly masculinity, the “sexual revolution”, population control, and women’s liberation. The growing acceptance – even popularity – of contraceptive sterilisation was dependant on the broader socio-political context of the second half of the twentieth century and on the willingness of individual medical clinicians to perform these procedures: formal policy or legislative change did not play a key role, therefore the experiences of individual doctors and patients are highlighted in order to understand this rise in popularity.\textsuperscript{22}

Chapter one provides an overview of the surgical history of tubal ligation and vasectomy from the nineteenth century to the 1980s. Surgical technology was vital to the widespread availability of contraceptive sterilisation in the 1970s and ‘80s because the


\textsuperscript{22} For example, Lewis traces the legal development of sterilisation in twentieth century Britain, outlining how contraceptive sterilisation became legal for consenting adults without any changes made to existing law. She instead attributes this development to changing public opinion, the increased support of the medical profession, and the influence of the Simon Population Trust established in 1957; Penney Lewis, ‘Legal Change on Contraceptive Sterilisation’, \textit{The Journal of Legal History} vol. 32, no. 3 (2011), pp. 295, 306-8.
increased medical acceptance of sterilisation was a result of developments in surgical technology that made these procedures safer, more efficient, and less invasive – in these circumstances, doctors were more willing to operate. Advances in technology have been integral in shaping contraceptive practices more generally, yet technology is often pushed aside in historiographical considerations of birth control in favour of socio-political narratives centred on sexuality and the family.²³ When it has occurred, analysis of contraceptive technology has often focussed on the chemical and physiological technologies of the pill, rather than surgical technology: further, surgical technology has been overlooked in recent historical analysis of eugenic sterilisation in favour of legislative development, public debate, and the coercive context in which these procedures were applied – Jesse Olszynko-Gryn’s work is an exception to this trend.²⁴ However, regardless of the context in which they were performed, tubal ligation and vasectomy are surgical procedures, the application of which was inextricably linked to medical practitioners and the technology they had at their disposal. Thus it is necessary to understand this changing technology in order to fully comprehend changing medical attitudes towards contraceptive sterilisation throughout the twentieth century.

Chapter two of this thesis presents a case for the separation of eugenics and contraception in the first half of the twentieth century in relation to practices of sterilisation: though interconnected concepts and practices, historical actors perceived a

clear distinction between eugenic and contraceptive applications of sterilisation, which is frequently overlooked.\textsuperscript{25} Eugenic sterilisation may have dominated public discussion, yet analysis of clinicians practicing in this period revealed that a desire for contraception characterised patients’ experiences of sterilisation in this context.\textsuperscript{26} This argument is illustrated by an analysis of the attitudes of “racial hygiene” associations and the Catholic Church towards sterilisation practices, and of individual doctors performing sterilisation procedures in this era – namely, Victor Hugo Wallace, Norman Haire, and Stefania Siedlecky. The purpose of this chapter is to establish a long tradition of contraceptive sterilisation, and one already apparent in the first half of the twentieth century, in order to challenge the frequent misconception that in this context, sterilisation was purely eugenic.

The 1950s and ‘60s are often characterised simplistically in popular memory – the former as a conservative backwater and the latter as a period of heightened sexual liberation.\textsuperscript{27} Chapter three is situated in this context and reconsiders these decades in light of the increasing public demand for contraceptive sterilisation. This chapter explores the rise of sterilisation practices during this period in relation to the overarching themes of gender, sexuality, and population. Within this, the analytic frameworks of masculinity and religion are employed in order to further highlight experiences of and attitudes towards contraceptive sterilisation during the 1950s and ‘60s. These frameworks are not typically invoked in histories of birth control, as the focus is often on women, however a study of masculinity and vasectomy illuminates individual motivations for sterilisation. Towards


\textsuperscript{26} Vasectomy patient records 1934-76, Boxes 63 and 65, Victor Hugo Wallace Collection, University of Melbourne Archives [hereafter VHWC].

the middle of the twentieth century, contraceptive responsibility – once consigned to the public, male world – was reconfigured as a female responsibility, and subsequent historiographical considerations have overlooked ongoing male involvement and constructed birth control as a ‘woman’s question’, an interpretive problem identified by Kate Fisher.28 Similarly, the Catholic uptake of sterilisation demonstrates the full extent of the social change that took place during these decades, yet the papal ban on birth control has often obscured the underlying history of contraceptive use found in the private experiences of the laity. In spite of the transformation witnessed during this period, sterilisation procedures frequently remained difficult to access as a result of their legal ambiguity, and the public demand for surgical contraception was not fully met until the 1970s and ‘80s.

The influence of international family planning programs, global concerns about overpopulation, women’s liberation, gay liberation, and the relaxation of traditional “family values” meant that sterilisation had ceased to be a private affair by the 1970s and ‘80s, and was instead a public and popular contraceptive option. Chapter four explores patient experiences of sterilisation during this period of unsurpassed popularity in order to emphasise the impact that surgical contraception had on individual lives by removing the anxiety created by potential unwanted pregnancies. For the most part, experiences of tubal ligation and vasectomy are considered separately throughout this thesis: although both procedures represent contraceptive sterilisation, they are highly gendered and this has affected experiences of surgical contraception. Because sterilisation is one of the few methods of contraception in which male and female practices can be so readily compared, this has extended my focus beyond the scope of female experience typically considered in

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histories of birth control, and has facilitated an analysis of gendered interaction and the contraceptive decision making process.\textsuperscript{29}

\textbf{Historiographical Positioning}

The themes and interpretive approach in the work of Frank Bongiorno, Lisa Featherstone, and Kate Fisher have significantly influenced the conceptualisation of this thesis.\textsuperscript{30} \textit{The Sex Lives of Australians} reconciles individual experience with the broader socio-political narrative of sex, using a ‘cornucopia of sexual tales’ to illustrate a comprehensive account of the history of sex and sexuality in Australia from 1788 to the present.\textsuperscript{31} Bongiorno argues that the social organisation of sexuality extends beyond the sphere of the personal and the private, into the realm of the social and the political, and this underlying argument characterises my analysis of surgical contraception.\textsuperscript{32} Contraceptive sterilisation was a fundamentally private issue in the first half of the twentieth century: though many elements of the private continued to characterise this history, contraceptive success was dependant on the broader socio-political context of the 1960s and ‘70s. In addition to Featherstone’s \textit{Let’s Talk About Sex}, Bongiorno’s overarching history contextualises the more obscure narrative of contraceptive sterilisation in Australia portrayed throughout this thesis. Within Featherstone’s history of sexuality from 1901-61, heightened emphasis is placed on public discussion rather than private practice in order to analyse the operation of power and authority in relation to sex in Australian societies.\textsuperscript{33} Religion, medicine, law, and popular culture are the subject of significant attention within this volume: although my

\textsuperscript{29} A more realistic understanding of historic birth control practices becomes increasingly likely when men are factored into this equation and contraception is viewed as part of a series of gendered interactions and decisions, rather than when discussion is restricted to women’s experiences. For example; Fisher, \textit{Birth Control, Sex, and Marriage}, pp. 189-237.

\textsuperscript{30} Bongiorno, \textit{The Sex Lives of Australians}; Featherstone, \textit{Let’s Talk About Sex}; Fisher, \textit{Birth Control, Sex, and Marriage}.


\textsuperscript{32} Bongiorno, \textit{The Sex Lives of Australians}, p. xv.

\textsuperscript{33} Featherstone, \textit{Let’s Talk About Sex}, p. 4.
own work emphasises the importance of practice over discussion, similar importance is attributed to these themes, as it was the extension beyond the private sphere and into public visibility in the second half of the twentieth century that led to the widespread availability of contraceptive sterilisation. Fisher’s analysis of masculinity in *Birth Control, Sex, and Marriage* has been equally influential, as her work is a rare acknowledgment of the presence of men in the history of contraception – a narrative that has frequently been constructed as a ‘woman’s question’. Supported by oral testimonies, Fisher’s research concludes that men played a dominant role in the history of birth control until the mid-twentieth century, during which time women’s involvement in such practices was the exception to this rule. This argument has been integral to my consideration of both vasectomy and tubal ligation in relation to the influence of gendered contraceptive responsibility on the application of these practices throughout the twentieth century. Yet surgical contraception is largely absent from all three of these histories.

Contraceptive sterilisation can be readily situated in several fields of historical scholarship – birth control, family planning, sex and sexuality, eugenics, population control, technology, and the history of medicine more generally – yet there is a dearth of literature available on this subject. Instead, contraceptive sterilisation is currently located on the periphery of several of these fields, displaced by a focus on ‘eugenic’ sterilisation. In his recent work on sterilisation as a global family planning initiative, Ian Dowbiggin argued that:

...the history of the sterilization movement is the untold story of the twentieth-century birth control movement, more important than the history of the Pill and rivalling the significance of the history of abortion… Yet for the most part, historians have either ignored the full history of this revolution in Americans’ contraceptive behavior or failed to recognize its formidable impact on birth rates and mores regarding sex and gender.  

The current historiographical configuration of eugenics and birth control in the twentieth century is not receptive to the history of contraceptive sterilisation. The uptake of contraceptive tubal ligation and vasectomy spanned many decades and this phenomenon requires consideration over the course of the twentieth century. In contrast, analysis of the eugenics movement, and with it eugenic sterilisation, is frequently confined to the first half of the twentieth century; while the periodisation of the history of birth control is often dictated by the introduction of the pill in 1960. These approaches artificially divide the twentieth century. In addition, sterilisation procedures have a deeply entrenched association with coercive circumstances and this continues to obscure the narrative of surgical contraception. Although there are exceptions to this periodisation, preconceived ideas about the history of eugenics and birth control in this period have concealed a

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37 Dowbiggin, The Sterilization Movement, pp. 3-4.


powerful narrative of contraceptive sterilisation. This thesis challenges current
constructions and periodisation of eugenic sterilisation and birth control and draws
attention to the impact of contraceptive sterilisation in the twentieth century in order to
raise the academic profile of this phenomenon.

Contraceptive sterilisation has often been misunderstood in histories of birth control
for the same reason that there is an absence of literature on this subject: the association
with coercion obscures this narrative and the pill dominates this discussion. Feminist
historian Linda Gordon writes on contraceptive sterilisation:

A 1982 study showed that 30 percent of former users of the Pill had turned to
sterilization as their birth control alternative. Was this increase in surgical
sterilization a net gain for reproductive and sexual freedom? Not necessarily,
because even when the surgery was voluntary the context often constrained
women’s choices. Many women enjoyed being free from the hassle of using
contraceptives, but they preferred contraception over sterilization because it
left open the option for further child bearing.

Gordon argues that women preferred reversible contraceptives to sterilisation, yet does not
provide evidence to support this claim. Instead her comment is based on unchallenged
assumptions made about the history of sterilisation. In an attempt to recognise the
experiences of those subject to coercive sterilisation, Gordon devalues the choices made by
women to undergo contraceptive sterilisation. A series of oral history interviews
showcased throughout this thesis reveal that for many women, tubal ligation was a life line

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40 Exceptions to this periodisation are more common within the historiography of birth control, for example: Hera Cook, The Long Sexual Revolution: English Women, Sex and Contraception, 1800-1975 (Oxford: Oxford University Press, 2004); Watkins, On The Pill; Barbara Baird, 'I had one too...': An Oral History of Abortion in South Australia Before 1970 (Adelaide: The Flinders University of South Australia, 1990); Schoen, Choice and Coercion. In contrast, Randall Hansen and Desmond King recently produced the first comprehensive analysis of eugenic sterilisation in the second half of the twentieth century; Hansen and King, Sterilized by the State.

41 Lesley A. Hall, Sex, Gender and Social Change in Britain since 1880 (Basingstoke: Macmillan, 2000), p. 177.

that freed them from the anxiety of unwanted pregnancy, and the coercive application of
this technology in other circumstances does not diminish the significance of this
experience.\textsuperscript{43} The history of the pill has similar aspects of coercion, for example the initial
human trials that took place on Puerto Rican women, yet this has not prevented its
widespread celebration as a contraceptive both in academic and popular considerations of
this phenomenon.\textsuperscript{44} While there is no denying the impact that the pill has had in relation to
changing attitudes towards contraception, developments in contraceptive technology, and
the availability of contraception, its dominance can overshadow the long established
characteristic of modern birth control more generally.\textsuperscript{45} In addition, the prioritisation of the
pill within histories of birth control has meant that focus is usually given to the
contraceptive practices of people under thirty, which ignores the subsequent years of
fertility faced by the pill-users who often turned to sterilisation upon entering their
thirties.\textsuperscript{46}

But what of the other areas of scholarship in which contraceptive sterilisation falls?
Jesse Olszynko-Gryn’s recent contribution to the history of sterilisation technology is one
of the few scholarly accounts of surgical contraception, in which he also questions the lack
of attention paid to tubal ligation in light of its historical significance.\textsuperscript{47} For the most part,

\begin{itemize}
\item \textsuperscript{43} Interview with Deborah Fielding\textsuperscript{8} by Tiarne Barratt, 23 April 2014.
\item \textsuperscript{44} Laura Briggs, Reproducing Empire: Race, Sex, Science and U.S. Imperialism in Puerto Rico (Berkeley:
University of California Press, 2002); Elaine Tyler May, America and the Pill: A History of Promise, Peril
\item \textsuperscript{45} Andrea Tone, Devices and Desires: A History of Contraceptives in America (New York: Hill and Wang,
2001), part one and two, pp. 3-202.
\item \textsuperscript{46} Bongiorno, ‘January 1961: The Release of the Pill’; Yorick Smaal, ‘Sex in the Sixties’, in Robinson and
However in the way that prioritisation of the pill overshadows the significance of sterilisation, the
prioritisation of sterilisation equally overshadows the popularity of other contraceptive methods including
injectable contraception and IUDs, barrier methods such as condoms, and traditional methods such as rhythm
and withdrawal. Similarly, a focus on sterilisation excludes particular groups of society from consideration:
the history of contraceptive sterilisation in Australia is anglocentric and fails to address the impact of race
and ethnicity on contraceptive practices; Rickie Solinger, Pregnancy and Power: A Short History of
\item \textsuperscript{47} Olszynko-Gryn, ‘Laparoscopy as a Technology of Population Control’, p. 148.
\end{itemize}
gynaecologists and urologists, rather than historians of birth control, have compiled histories of tubal ligation and vasectomy.\textsuperscript{48} This has created a body of work that places a strong emphasis on the significance of exact dates and uncovering the “first” person to invent a certain technique or to perform a specific procedure, without consideration of the broader socio-political context of these events, or of patient experiences. In contrast, contraceptive sterilisation is often absent in histories of population control and international family planning programs, because these works tend to operate on a larger-scale and the broader socio-political context takes focus over a narrative of individual experience.\textsuperscript{49} My thesis draws from these various bodies of work in which contraceptive sterilisation currently exists on the periphery of, and situates surgical contraception within the history of birth control in the twentieth century: once the necessity of separating voluntary and involuntary embodiments of sterilisation procedures is recognised, it becomes apparent that contraceptive sterilisation represents an important contribution to this field.

### Primary Sources as Methods

Due to the private and personal nature of experiences of contraceptive sterilisation, there is limited published material available on this subject and I have undertaken twenty


interviews with practitioners, patients, and members of the Catholic clergy in order to illuminate this history.\textsuperscript{50} This approach to the history of birth control is relatively new within existing literature and is beneficial because it injects personal experience and micro-level analysis into the consideration of larger-scale contraceptive trends.\textsuperscript{51} Kate Fisher recently defended the use of oral history within histories of sex and sexuality: though there are limitations to this approach, for example, small sample sizes, lack of representation, the error of human memory, and the subjective nature of this material, these traits need not necessarily be viewed as negative. The subjective nature of oral history is revealing, particularly in relation to the intimacy of the narrative of sterilisation, and the subjectivities of oral history create points of analysis by highlighting themes that are inaccessible in written sources.\textsuperscript{52} In addition, the researcher is in a position to cross-check interview material for internal consistency – which has been done throughout this thesis. In 1982, when the methodological framework of oral history still required robust defence, Paul Thompson argued that ‘Oral history is at the same time the newest and the oldest form of history.’\textsuperscript{53} Highly valued for countless generations, the validity of oral traditions was not questioned until the rise of professional academic history and the development of recording technology, both of which emphasised “accuracy” within human memory and historical narratives. Oral histories are reflections of past events, altered by time and memory but no less real or important, and all sources are subject to a certain degree of interpretation and negotiation.\textsuperscript{54} Though the majority of primary material used

\textsuperscript{50} ‘The Normalisation of Contraceptive Sterilisation in post-war Australia’, Project No. 2013/534, approved by The University of Sydney Human Research Ethics Committee (HREC), 4 July 2013.
\textsuperscript{*} indicates use of pseudonym.
\textsuperscript{51} Fisher, \textit{Birth Control, Sex, and Marriage}, p. 3.
\textsuperscript{52} Fisher, \textit{Birth Control, Sex, and Marriage}, p. 13; Baird, ‘I had one too…’, p. 5.
comes from oral histories, archival material has been equally significant, which has additionally been supplemented by a range of published sources – for the most part medical texts and journals such as, *The Medical Journal of Australia*, the *British Medical Journal*, and the *Journal of the American Medical Association*.

Contrary to the belief that legislative development determined the prevalence of sterilisation procedures, it was a small group of individual medical practitioners who altered national practices of tubal ligation and vasectomy: for the majority of the twentieth century, individual doctors acted as an unofficial governing body for sterilisation procedures, elevated to this status by their exclusive medical knowledge and surgical training. The experiences of Haire, Wallace, Siedlecky, Errey, Simcock, and Stewart have been invaluable as they provided first-hand insight into the normally closed world of the medical profession. Analysis of Haire and Wallace is solely archival, and in depth interviews were conducted with Siedlecky, Errey, Simcock, and Stewart. The avenues of enquiry that located these doctors initially began with a discussion with senior members of staff at Family Planning New South Wales (NSW) who remembered the rise of contraceptive sterilisation in the early 1970s and identified several people whom they thought to have been directly involved. This then had a “snowballing” effect and enabled me to contact and interview the doctors who had been integrally involved in the rise of surgical contraception in Australia – their memories have shaped this research.


56 For various reasons, the other key medical figures in this narrative were unavailable for study: some did not wish to participate in the project and requested to remain anonymous, others were unable to be located after their retirement, and of the older generations many had already passed away prior to the commencement of this research, and unlike Haire and Wallace they did not leave behind archives detailing their practice.
With his mother originally from London and his father a Jewish emigrant from Poland, Haire was born Norman Zions in Sydney in 1892, the eleventh and final child in his family. After graduating from the University of Sydney in 1915 with a Bachelor of Medicine and a Master of Surgery, he later became one of the early twentieth century’s pioneering sexologists.\footnote{Wyndham, \textit{Norman Haire and the Study of Sex}, chapter one ‘Early Years’; Alison Bashford and Carolyn Strange, ‘Public Pedagogy: Sex Education and Mass Communication in the Mid-Twentieth Century, \textit{Journal of the History of Sexuality} vol. 13, no. 1 (2004), pp. 71-99; Bongiorno, \textit{The Sex Lives of Australians}, p. 167.} Following a series of medical appointments upon graduation, including Chief Medical Officer at the Royal Hospital for Women in 1917, Haire moved to Britain in 1919 where he pursued his interest in eugenics, contraception, and sexology and came into contact with well-known figures of the time including, Havelock Ellis, Margaret Sanger, Magnus Hirschfield, and Edward Carpenter – twenty years passed before he returned to reside in Sydney. A background in surgical gynaecology and the “rejuvenating” properties of vasectomy meant that Haire was uniquely situated to perform both male and female sterilisations – a rare aberration in the twentieth century medical community. Though he performed both tubal ligation and vasectomy in his private practice from the early 1920s onwards, it is primarily his work in the 1940s that is considered here: surprisingly for his liberal persona he was not an advocate of contraceptive sterilisation.\footnote{Norman Haire, ‘Birth Control’, in Norman Haire eds., \textit{Some More Medical Views on Birth Control} (London: Cecil Palmer, 1928), p. 48; Wykeham Terriss, ‘A Doctor Looks at Life – Sterilisation Queries’, \textit{Woman}, 23 April 1945, Box no. 2.25 (2), NHC.}

Upon his death, Haire bequeathed an extensive collection of personal papers to the University of Sydney and this archive has been used to analyse his sterilisation practice.

Born in 1893, Melbourne based doctor Victor Hugo Wallace was a second generation Australian of English and Scottish heritage.\footnote{Victor H. Wallace, \textit{The Wallace Story} (Victoria: Progress Press, 1973), introduction.} Wallace graduated from the University of Sydney in 1918 and shortly after commenced a tour of Europe, where he was considerably influenced by the ‘valuable pioneering’ work of Marie Stopes and the birth
control clinic she ran in London. Upon his return to Australia, Wallace entered private practice in 1928 and provided patients with birth control and contraceptive advice in the context of the financial hardship wrought by the Depression. He began performing vasectomies less than six years later in 1934, and this coincided with his establishment of the first birth control clinic in Victoria, the Women’s Welfare Clinic (WWC) located in Fitzroy. Like Haire, Wallace bequeathed an extensive archival collection to the University of Melbourne that detailed his medical career and professional interest in eugenics and contraception. This archive has been used in relation to the vasectomy patient records from 1934-76 that it contains: these records illustrate Wallace’s practice and provide unique insight into patient experiences of sterilisation in this context.

Stefania Siedlecky has made an impressive contribution to women’s healthcare in Australia. She was a gynaecologist at the Rachel Forster Hospital for Women and Children from the 1940s-70s; she occupied a senior advisory position at Family Planning NSW in the 1970s and ‘80s; she founded the Leichhardt Women’s Health Centre in 1974; she worked as a consultant in Family Planning in the Commonwealth Department of Health from 1974-86; in 1990 she co-authored one of the seminal texts on the history of birth control in Australia; and throughout her career she fought for women’s increased access to all forms of reproductive healthcare. Originally from a low socio-economic background, Siedlecky was awarded a six-year university bursary to study medicine at the University of Sydney, from which she graduated in 1943. Her initial interest had been school teaching, however the presence of cataracts in her eyes led to a rejection from the Sydney Teachers College: reflecting back on this experience at the age of ninety-two, Siedlecky regarded it

60 Victor Hugo Wallace, ‘The Development of Family Planning in Australia’, unpublished manuscript, (1977), pp. 4-5, Box 35, VHWC; ‘Patient History Cards’, Box 63, VHWC.
as one of the strangest, yet luckiest moments of her life, as it meant that she instead pursued a medical career through which she was able to have a significant impact in the arena of reproductive health.\textsuperscript{62} In 2013, Siedlecky was interviewed for this project about her contribution to the practice of contraceptive sterilisation in Australia: from the late 1940s to the late 1980s Siedlecky performed tubal ligation procedures both in private practice and in public hospitals on women who requested permanent contraception, making her one of the first doctors to meet the public demand for contraceptive sterilisation.

Within the next generation of medical professionals, Bruce Errey was one of Australia’s most prolific vasectomists, with a total of 30,040 operations performed over four decades (1970-2007).\textsuperscript{63} Errey graduated from the University of Melbourne in 1954 and made a name for himself in general practice by providing his patients with contraception – an interest that he continued to pursue upon his relocation to Queensland (QLD) in 1969. Errey ran a private vasectomy clinic in Brisbane from 1974-2007 and was extremely invested in his career – vasectomy was his passion as well as his livelihood. He celebrated every thousandth vasectomy operation he performed with an office party, complete with a birthday cake for the patient, who presided as the guest of honour. He took great pride in personally undergoing vasectomy in 1971, and confessed that he continues to thoroughly enjoy ‘boasting’ about the success of his clinic and the personal impact he had on the history of vasectomy in QLD.\textsuperscript{64} It is unsurprising that Errey had such a personal investment in his vasectomy career: it enabled him to travel both locally and internationally and to pursue his interest in population control.\textsuperscript{65} It was a sociable job –

\textsuperscript{62} Interview with Stefania Siedlecky, 2 September 2013.
\textsuperscript{63} Private correspondence between Bruce Errey and Tiarne Barratt, 20 November 2013.
\textsuperscript{64} Interview with Dr Bruce Errey by Tiarne Barratt, 15 January 2014.
\textsuperscript{65} See Figure 4.3. ‘Trouble Parking? Support Zero Population Growth’, BEPC.
characterised by new, grateful, and satisfied patients every week – and it gave him surgical prestige and status amongst his peers, despite the fact that he was only trained as a general practitioner. Errey kept an extensive personal archive from 1970 onwards, which has been used in conjunction with a series of correspondence, and a 2014 interview in order to analyse vasectomy practices in the second half of the twentieth century.

Barbara Simcock was an equally pioneering – if less enthusiastic – Australian vasectomist, operating from 1972-2006. Upon graduation from the Royal College of Physicians in London in 1959, Simcock and her husband migrated to Australia where she began work with Family Planning NSW in 1968. Simcock had more of an interest in women’s reproductive healthcare than Errey, influenced by her familial background in gynaecology and demonstrated by the many years she spent at Family Planning. In 1972, Simcock’s career took her in a new direction of contraception when she started the first outpatient vasectomy clinic in Australia via Family Planning NSW. In preparation for this, Simcock travelled to India and observed Indian vasectomy techniques at the Family Planning hospital for two weeks and her experience provides a unique perspective on Indian sterilisation practices in the 1970s. In addition, Simcock played an instrumental role in the creation of the Australian Association for Voluntary Sterilisation and she continued to import the latest international vasectomy technology to Australia throughout her career. Simcock was interviewed for this project in 2013, which represented the first time the history of her vasectomy clinic had been considered in any significant detail.

Bruce Errey, ‘6,367 Vasectomies’, Bulletin of the Post-Graduate Committee in Medicine, University of Sydney (November 1977), BEPC; Lecture by Bruce Errey, Sixth World Medical and Legal Conference, Ghent Belgium, 22 August 1982, in BEPC.

Dr Errey’s private archives were an extensive and unique source of information, however this being a private collection, Errey determined what was accessed and to a certain extent this limited the scope of this collection.

Interview with Dr Barbara Simcock by Tiarne Barratt, 24 July 2013.

Ian Stewart represented the youngest generation of doctors interviewed for this project and in 2013 he was still involved in the non-surgical elements of medical practice and nearing his retirement. Stewart graduated from the University of Sydney in 1967 and pursued a career in obstetrics and gynaecology, including laparoscopic tubal ligation.\textsuperscript{70} Early in his medical degree, Stewart came to the realisation that he did not wish to spend his career caring for the chronically ill: this coincided with his further study of obstetrics and gynaecology, which led him to develop a special interest in this field. Following a series of surgical and obstetric appointments, Stewart temporarily relocated to London for further training, where he became confident with laparoscopic technology in the early 1970s. Upon his return to Australia, he was offered an obstetric position in Wagga Wagga in rural NSW, where he spent the remainder of his career providing surgical contraception in a town with a large Catholic community: tubal ligation has remained controversial in Wagga Wagga in the twenty-first century due to this Catholic presence.\textsuperscript{71} In addition to doctors, three priests responded to a call to discuss the Catholic Church and the increasing uptake of surgical contraception in the twentieth century, another area that has remained relatively closed to the public in regards to experiences of sterilisation.\textsuperscript{72}

In addition to doctors and priests, interviews with patients of contraceptive tubal ligation and vasectomy made a substantial contribution to the primary material used in this thesis. The demographic criteria for these interviews was indiscriminate and this process was open to any interested member of the Australian public who had used sterilisation as a method of contraception from 1960-85.\textsuperscript{73} This resulted in a focus group that was

\textsuperscript{70} Laparoscopic surgery refers to "key-hole" surgery: see chapter one, ‘The Surgical History of Tubal Ligation’ for a detailed explanation of laparoscopy and the technology that preceded it.

\textsuperscript{71} Interview with Ian Stewart, 26 November 2013.

\textsuperscript{72} Interview with Father Mark Davidson*, written response completed 10 April 2014; Interview with Father Daniel Watson*, written response completed 6 May 2014; Interview with (late) Professor Nicholas Tonti-Filipini by Tiarne Barratt, 20 June 2014.

\textsuperscript{73} See Appendix A for the questionnaire that respondents were provided with.
predominantly female, white, and middle class, which in many ways was unsurprising as this was the group most likely to employ contraceptive sterilisation in the second half of the twentieth century in Australia. Participants were recruited in several ways: online advertising through australiansenior.com, a call for participants in the Oral History Association of NSW newsletter, a call for participants posted to retirement homes throughout Australia, and by word of mouth. This resulted in fifteen respondents, however four people chose to discontinue their participation, leaving a total of eleven respondents in the study. Participants resided in four states of Australia – New South Wales, Queensland, Victoria and Western Australia – and had birth dates ranging from 1928 to 1955. For the most part, these interviews took place via the format of a written questionnaire, however when the respondent was within a convenient geographical distance to the researcher, the interview was conducted in this manner. The majority of the operations discussed took place in capital cities, even those experienced by people living in rural areas, as contraceptive sterilisation was more readily available in major cities than smaller towns for a large part of the twentieth century. The permanent nature of sterilisation meant that patients were often required to consider this contraceptive choice more carefully than their use of reversible contraceptives, which helped respondents to recall the events that led to their sterilisation. In conjunction with patient records from the Wallace and Errey archives, these interviews reveal that sterilisation was often a last resort

75 This thesis explores the rise of contraceptive sterilisation in Australia, by which ‘Australia’ for the most part refers to the history of capital cities, namely Sydney, Melbourne and Brisbane. Although sterilisation procedures did take place in other regions of Australia, the majority of operations were performed in cities as they had a larger population, a higher concentration of doctors, and the latest technology. Further, cities have historically been a point of activity, progressive thought and anonymity, all of which were required for covert sterilisation procedures to take place prior to the widespread normalisation that occurred in the 1970s; Robert Aldrich, ‘Homosexuality and the City: An Historical Overview’, in Alan Collins ed., Cities of Pleasure: Sex and the Urban Socialscape (London and New York: Routledge, 2006), pp. 90-1.
for many couples and that its increased availability often removed anxieties about unwanted pregnancy.

By tracing the gradual rise of contraceptive sterilisation through the experiences of both doctors and patients, this thesis offers a new perspective not only on the nature of birth control practices in the twentieth century, but on the position of sterilisation in wider histories of eugenics, coercion, contraception, and sexuality. The interviews conducted for this research revealed that eugenic and contraceptive sterilisation were interrelated yet separate phenomena; that eugenic sterilisation took place throughout the twentieth century and was often performed by the same clinicians who provided voluntary surgical contraception; that it was an overwhelming public demand for reliable, long-term contraception that facilitated the popularity and contraceptive success of sterilisation; and that understandings and exploration of gender, sexuality, and sexual pleasure were intrinsically connected to the rise of contraceptive sterilisation. Hundreds of thousands of Australians were affected by the normalisation of surgical contraception in the second half of the twentieth century, and the impact of sterilisation has been comparable to that of the pill: indeed it has been all the more notable as unlike oral contraceptives, sterilisation procedures did not have the financial support of the global pharmaceutical industry.
Chapter One – Sterilisation Technologies

Introduction

Sterilisation practices are typically considered within the scope of eugenics, coercion, family planning, or contraception. However tubal ligation and vasectomy are specific medical procedures with a separate surgical history that enriches socio-political readings of sterilisation practices. The rise of contraceptive sterilisation in the twentieth century was inextricably linked to the medical profession, whose attitudes were largely shaped by the surgical technology available to perform tubal ligation and vasectomy. As sterilisation procedures became increasingly time efficient, cost effective and minimally invasive, doctors became more willing to perform elective surgery in contraceptive circumstances, which increased the availability of surgical contraception. Technology has been similarly influential in shaping contraceptive availability more generally, and for this reason it is an important part of the wider historiography of birth control.¹ This chapter establishes tubal ligation and vasectomy as longstanding surgical procedures and explains in detail the development and uptake of these technologies both locally and internationally, from the nineteenth century to the 1980s. Drawing on the experiences of Australian doctors, Norman Haire, Victor Hugo Wallace, Stefania Siedlecky, Bruce Errey, Barbara Simcock and Ian Stewart, tubal ligation and vasectomy are considered separately. Although both represent contraceptive sterilisation, the surgical history of these procedures is as different as the male and female body. The history of tubal ligation is one of continuously advancing technology, driven by a demand for minimally invasive female sterilisation. By contrast, the history of vasectomy has been propelled by public perception, in particular

the way the procedure interacts with understandings of castration, masculinity, and sexuality. In both cases, the surgical developments depicted are an integral aspect of the history of surgical contraception: they help elucidate medical attitudes and a command of this technology provides insight into the rise contraceptive sterilisation throughout twentieth century.

Existing literature on the surgical history of tubal ligation consists of a small, increasingly outdated body of work that has been largely compiled by members of the gynaecological profession.² Within this, strong emphasis is placed on the significance of exact dates and uncovering the “first” person to invent a certain technique or to perform a specific procedure. Gynaecologist and medical historian Harold Speert is considered authoritative, receiving much praise for his work in linking specific gynaecological practices to their namesakes.³ Similarly, existing surgical histories of vasectomy often come from practitioners within the field of urology.⁴ This approach has created a body of work that focuses on exact dates and figures, rather than the impact or uptake of this technology. In contrast, historians of medicine seek to chart the history of innovation by tracing the transmission of knowledge and the dissemination of technology, analysing why certain trends in surgical practice occurred and the impact that they had, rather than their

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origins. Jesse Olszynko-Gryn recently made the first contribution of this kind to the history of tubal ligation technology, however the same is yet to be done for vasectomy. This focus on effect is similarly applied elsewhere, for example, within considerations of the broader socio-political impact of sterilisation in the context of international family planning and global fertility – yet the history of surgical technology is rarely the subject of significant attention within these narratives. While there are exceptions to this rule, it is unusual to find the history of sterilisation technologies prioritised outside of gynaecological or urological literature and doing so here outlines the extent to which surgical technology has contributed to the phenomenon of contraceptive sterilisation. In doing so, it becomes apparent that surgery is subjective and individual doctors have played a key role in this history. This chapter draws on existing literature, returning to cited primary sources wherever possible, and is supplemented by additional research and oral history interviews in order to focus this international narrative on Australian sterilisation practices.

The Surgical History of Tubal Ligation

Tubal ligation, known in lay terms as “tying the tubes”, is the surgical procedure most commonly employed to achieve female sterilisation and describes an operation that blocks a woman’s fallopian tubes, rendering her permanently sterile. Both historically and contemporarily, tubal ligation procedures have been comprised of two main surgical

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components – methods of occluding the fallopian tubes, and methods of approaching the fallopian tubes. Methods of occlusion refer to the way in which the fallopian tubes are obstructed in order to bring about sterility, while methods of approach refer to the way in which a surgeon gains access to the fallopian tubes in order to occlude them.\textsuperscript{10} Methods of occlusion fall into three main categories: traditional surgical ligation, division or excision, which involves tying, cutting or removing a section of the tubes; mechanical devices such as clips and bands placed on the tubes and designed to block them; and non-surgical methods, the most successful of which has been electrocautery, and involves burning a section of the tubes in order to seal the passage. Methods of approach also fall into three categories: transvaginal, transcervical, and abdominal.\textsuperscript{11} Transvaginal approaches were popular in the 1960s and ‘70s due to their time efficiency, but are no longer recommended, while experimentation with transcervical techniques was only just beginning in the 1980s and was not incorporated into sterilisation practice until the twenty-first century. In contrast, abdominal methods of approach have been applied consistently throughout the twentieth century and the technologies of laparotomy (open abdominal surgery), minilaparotomy (open surgery with a smaller incision) and laparoscopy (key-hole surgery) were most frequently employed in practices of contraceptive sterilisation in twentieth century Australia. Throughout this history, methods of approach have determined the parameters of occlusion technology because entering the abdomen where the fallopian tubes are located is the most physically demanding aspect of the procedure for the patient. These technologies work in conjunction with one another and as a result, techniques of

occlusion and approach have played an equally important role in the surgical history of female sterilisation.

Throughout the history of sterilisation, there has never been one “correct” method of tubal ligation and studying general trends in surgery sheds light on experiences of female sterilisation. Within surgery, as within all branches of medicine, trends come and go, operations move in and out of fashion, technology advances, and techniques are subject to the preferences of individual doctors and the resources available to them. The majority of tubal ligation techniques currently in vogue were developed over the second half of the twentieth century, although some were in circulation earlier than this. In the 1980s, there was a plateau in surgical innovation and this demonstrates the extent of the technological advances made in the second half of the century. The most dramatic change witnessed was one that affected surgical practice more generally, the development of the laparoscope and the introduction of minimally invasive ‘key-hole’ abdominal surgery in the 1960s. The introduction of the laparoscope meant that abdominal surgery became less physically demanding and it drastically reduced patients’ post-operative recovery time and pain. Patient safety was a priority and advances in surgical technology contributed to the increasing prevalence of surgical contraception. The developments in laparoscopic surgery were all the more significant for the context in which tubal ligation originated in: doctors shied away from abdominal surgery in the eighteenth century because of its high mortality rate, and prior to nineteenth century advancements in antiseptic practice,

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gynaecological surgery was considered a radical and dangerous last resort rather than a viable medical treatment.¹⁴

The late nineteenth century saw a dramatic improvement in medical hygiene, namely the widespread uptake of Listerian antiseptic practices. Joseph Lister is now distinguished in medical histories as the pioneer of modern surgical antiseptic practices, considered revolutionary for his contention that post-operative mortality rates were caused by infection and could be minimised with an improvement in hygiene.¹⁵ The uptake of Listerian practice was a long and difficult process and the subject of extensive medical criticism – many of Lister’s contemporaries never embraced his views. However once the uptake of antiseptic was achieved, surgery became an increasingly frequent aspect of standard medical practice as a newfound attention to hygiene led to a decline in mortality rates.¹⁶ Before long, gynaecological surgery reports and discussion filled the pages of the Australian Medical Gazette, causing Australian doctor J.O. Closs to note that in 1886, abdominal operations were ‘common enough in these days’, when only years before they had been an infrequent and dangerous occurrence.¹⁷ Yet it was not only advances in hygiene that altered perceptions of abdominal surgery. During this time a “therapeutic revolution” was underway, which encouraged medicine to become localised to specific

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areas of the body. This resulted in the rise of gynaecology as a specialised branch of medicine and subsequently inspired surgical practice and experimentation within this field. These combined breakthroughs in surgical technology and general medical attitudes meant that by the eve of the twentieth century, opening the abdomen had become the practice of ‘surgeons of all nations.’

Prior to the twentieth century, abdominal surgery largely consisted of therapeutic operations such as hysterectomy, ovariectomy (removal of the ovaries, i.e. female castration), salpingectomy (removal of the fallopian tubes), or caesarean section. With the exception of caesarean section, these procedures had a sterilising effect on women, yet the intent was to treat gynaecological disorders of the uterus, ovaries and fallopian tubes, rather than to prevent pregnancy. Tubal ligation was scarcely practiced in the late nineteenth century and a shift in surgical intent was integral to the development and implementation of tubal ligation technologies – sterility had to become the purpose of the operation, rather than a side effect, before female contraceptive sterilisation could advance. In the 1820s and ‘30s, English obstetrician James Blundell initiated some of the earliest discussion of tubal ligation as a form of birth control. Although Blundell has been primarily remembered for his work relating to blood transfusion, he was also a pioneer of modern obstetrics and abdominal surgery. In a context where abdominal surgery was a


22 James Blundell, Observations on some of the more important Diseases of Women (Philadelphia: A. Waldie, 1840).
radical notion in therapeutic circumstances, let alone for the express purpose of contraception, Blundell suggested removing a section of the fallopian tubes to induce sterility in women for whom further pregnancies were considered medically dangerous:

In my opinion… if a woman were in that condition… I would advise an incision of an inch in length in the linea alba above the symphysis pubis; I would advise further, that the fallopian tube on either side should be drawn up to this aperture; and, lastly, I would advise, that a portion of the tube should be removed, an operation easily performed, when the woman would, for ever after, be sterile.  

The technique described here, of abdominal incision followed by excision of the fallopian tubes, is one that was employed frequently throughout the first half of the twentieth century to achieve female sterilisation. While it is unlikely that Blundell ever advanced beyond experimentation in animals, his work is significant because it introduced the idea of non-therapeutic abdominal surgery to explicitly prevent pregnancy, marking the beginning of tubal ligation’s twentieth century contraceptive success.

Harold Speert has attributed the first successful tubal ligation procedure to Ohio doctor, S.S. Lungren, operating on Marie Kaiser in 1880. Although the exact origin of the procedure is a point of contention amongst historians and then contemporaries alike, there is no doubt that gynaecological surgery was flourishing by the late 1880s, and the case study of Lungren demonstrates the surgical techniques employed by early practitioners of female sterilisation. After performing a second caesarean section on Kaiser, Lungren considered that her circumstances warranted sterilisation in order to

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prevent the possibility of a third caesarean as there was a longstanding belief that multiple caesarean sections represented a danger to the patient.\textsuperscript{27} Initially, Lungren had planned to perform an ovariectomy via open abdominal surgery to sterilise Kaiser, however a high possibility of hemorrhage meant that ‘the Fallopian tubes were tied instead with a strong silk ligature about one inch from their uterine attachment.’\textsuperscript{28} In this incidence, Lungren relied purely on ligation to occlude the tubes – a technique that has long since been abandoned due to the resilient nature of the fallopian tubes and the high likelihood this method presents for recanalisation (natural rejoicing of the tubes). By the early twentieth century it was commonly accepted that ligation needed to be accompanied by division or excision of the tubes in order to be effective, and with the exception of safety, the need to prevent recanalisation was one of the main factors propelling technological advancement within female sterilisation.\textsuperscript{29} In conjunction with ligation, Lungren used an abdominal method of approach that is otherwise known as laparotomy and refers to a surgical incision into the abdominal cavity that is greater than five centimetres.\textsuperscript{30} Until the widespread uptake of laparoscopic (key-hole) surgery in the 1970s, laparotomy was the most popular method of approach – indeed it was the only method of approach used in the first half of the twentieth century. Laparotomy was characterised by long operating and convalescing times, high rates of wound infection, and postoperative pain, which led Norman Haire to remark that female sterilisation was ‘a major operation, necessitating two weeks in bed’.\textsuperscript{31}

\textsuperscript{27} It remained medically inadvisable to exceed three caesareans until the late twentieth century: for example, both Stefania Siedlecky and Ian Stewart recalled that for the majority of their careers, tubal ligation was often recommended in conjunction with a second or third caesarean; Interview with Dr Stefania Siedlecky by Tiarne Barratt, 2 September 2013; Interview with Dr Ian Stewart by Tiarne Barratt, 26 November 2013.


\textsuperscript{31} March, ‘Tubal Sterilization’, pp. 134-7; Wykeham Terriss, ‘A Doctor Looks at Life – Sterilisation Queries’, \textit{Woman}, 23 April 1945, Box 2.25 (2), Norman Haire Collection, University of Sydney Rare Books Collection [hereafter NHC].
As methods of approach and occlusion became more sophisticated, sterilisation became both safer and more effective in preventing pregnancy and this contributed to the increasing prevalence of contraceptive tubal ligation.

Within traditional methods of tubal occlusion, the Madlener technique of crushing the fallopian tubes was popular from the early twentieth century until the 1970s. Named after German doctor, Max Madlener, this technique involved crushing the fallopian tubes.

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with heavy forceps, so that the tissue was crushed ‘paper thin’, after which a ligature
would be applied to the crushed section of the tube, and the tube returned to the
abdomen.\textsuperscript{33} The operation was devised in approximately 1910 and within Madlener’s 166
personal test cases, he reported no failures. However the method was not so successful
when employed by other surgeons, and subsequent proprietors of the Madlener technique
reported a failure rate between approximately two to eight per cent, which led to its
eventual disappearance from surgical practice.\textsuperscript{34} In the early twentieth century, American
doctor Ralph Hayward Pomeroy began to practice a technique of tubal ligation that was
thought to have been developed by a French doctor, A. Crimail, in the early 1890s.\textsuperscript{35} This
method of occlusion required that a loop be made in the fallopian tube and that the two
arms of the loop be tied together, after which a section of the tube was removed.\textsuperscript{36} ‘The
loop of tube is cut across cleanly with scissors or knife, leaving just enough tissue to
suffice for adequate stumps, so that the catgut will not slip off as the amputated ends flair
upward.’\textsuperscript{37} The looping and excision of the tubes suggested a desire to prevent
recanalisation, whilst the absence of crushing was indicative of surgeons’ aspirations to
design a technique of occlusion that was successful, but also readily reversible – both
factors were significant motivators in the development of female sterilisation technologies.
Pomeroy has been accredited with popularising this technique in the 1920s and ‘30s, and it
has since been known as the Pomeroy operation, underscoring Pomeroy’s perceived
influence in the dissemination of the method.\textsuperscript{38} The Pomeroy method of sterilisation has

\textsuperscript{33} See Figure 1.1; Max Madlener, ‘Über sterilisierenden Operationen an den Tuben’, (1919), in Speert,
\textsuperscript{34} Frank C. Irving, ‘Tubal Sterilization’, \textit{American Journal of Obstetrics and Gynecology} vol. 60, no. 5
\textsuperscript{35} John Ellison et al., \textit{Sex Ethics: The Principles and Practice of Contraception, Abortion, and Sterilization}
\textsuperscript{36} See Figure 1.2.
\textsuperscript{37} Robert L. Dickinson and Clarence J. Gamble, \textit{Human Sterilization: Techniques of Permanent Conception
\textsuperscript{38} Dickinson and Gamble, \textit{Human Sterilization}, pp. 10-11; Ross et al, \textit{Voluntary Sterilization}, p. 33; Wood,
\textit{Vasectomy and Sterilization}, p. 38.
remained consistently popular from the 1930s to the twenty-first century, and “Pomeroy” is still generally doctors’ first choice when a sterilisation procedure requires a traditional method of surgical occlusion. For example, Ian Stewart was taught to perform tubal ligations using this technique in the 1960s and continued to apply the Pomeroy method throughout the following decades of his career any time he was required to perform sterilisation via laparotomy.\(^{39}\) Although other surgical techniques have been used throughout this time period, none rivaled “Pomeroy” in terms of simplicity, time efficiency, or the minimal physical strain put on the patient.\(^{40}\)

As abdominal incisions became smaller with the introduction of minilaparotomy in the 1970s, “Pomeroy” remained surgically viable and the technique retained its popularity due to its simplicity and efficiency, unlike examples such as the Irving method of occlusion. “Irving” refers to a technique of tubal ligation popularised by American gynaecologist Frank Irving in the first half of the twentieth century, and it involved burying the divided ends of the fallopian tubes in the abdominal cavity.\(^{41}\) Norman Haire was a particular advocate of this technique when performing tubal ligations in the 1940s and he chose to provide people with information on both “Pomeroy” and “Irving” in the context of his public lectures and instructive manuals.\(^{42}\) As with Pomeroy, Irving did not conceive of the idea, but his role in propagating the technique – which resulted in its name – created the perception that he invented the technique, when in actuality the idea had been discussed by others before him, whether he was aware of it or not.\(^{43}\) Designed to work in

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\(^{39}\) Interview with Ian Stewart, 26 November 2013.
conjunction with caesarean section in order to avoid unnecessary abdominal surgery, Irving’s technique was developed in response to the failure rates associated with “Madlener” and the occurrence of ectopic pregnancy associated with “Pomeroy”.44 Throughout the twentieth century Irving’s technique remained a popular choice when combined with caesarean. However since the gradual disappearance of laparotomy in gynaecological surgery due to technological developments of the 1960s, “Irving” has often been set aside in favour of techniques that do not require such a large abdominal incision, as the absence of caesarean section acts as a contraindication to this method.45

The transvaginal approach to female sterilisation bypassed the need for abdominal surgery. It was devised as a solution to the pressure that abdominal sterilisation put on busy hospitals in terms of the increased need for operating theatres and beds that occurred when contraceptive sterilisation became increasingly popular in the 1960s. The transvaginal approach was more cost effective and time efficient than laparotomy, which made it a highly attractive method within family planning programs directed towards developing countries and low socio-economic groups prior to advances in minilaparotomy and laparoscopy.46 In contrast to abdominal sterilisation, transvaginal procedures could be performed as an outpatient procedure in any room that had an operating table, thus minimising the need for long hospital stays.47 This was desirable for both doctors and patients and as a result transvaginal sterilisation was, albeit briefly, a widely adopted

47 Alfonso J. Gutierrez Najar, ‘Culdoscopy as an Aid to Family Planing’, in Duncan et al. eds., Female Sterilization, p. 41.
approach to female sterilisation. This method was popular amongst patients because of the lack of scarring, the minimal post-operative discomfort, and the speed of the recovery, which meant that they did not need to be in hospital for more than a day.\textsuperscript{48} Although the transvaginal approach is no longer recommended due to high rates of infection, pain, surgical mishap, and failure associated with the approach, it did experience a brief surge in popularity during the late 1960s and early 1970s.\textsuperscript{49} Depending on the surgeon involved and the context of the operation, the transvaginal approach was used in Australia into the 1970s: one respondent to this project recalled that she was sterilised inter-vaginally in Sydney in 1972, with a short recovery time, no complications and no scarring.\textsuperscript{50} Similarly Ian Stewart remembered a period in the 1970s when he performed vaginal tubal ligations on women with uterine prolapse, for whom laparoscopy or open surgery was not recommended. Stewart described the procedure:

\begin{quote}
…if you can get the uterus to tilt backwards and put the tubes into the pelvis, then you can pull them into the vagina through a small incision, take a piece out of them, put them back in, two stiches in the vagina and that lady can go home certainly no later than the next morning.\textsuperscript{51}
\end{quote}

Using the transvaginal approach, various methods of occlusion could be applied, the most popular of which were the Pomeroy technique, electrocautery, or Hulka clips.\textsuperscript{52} However, in the interests of patient safety, this method of approach had been largely abandoned by the 1980s in favour of the abdominal techniques of minilaparotomy and laparoscopy.\textsuperscript{53}

Minilaparotomy refers to an incision of five centimeters or less. It was developed in the late 1960s and popularised in the early 1970s in response to the growing demand for

\begin{footnotes}
\textsuperscript{48} Little, ‘Culdoscopic Outpatient Sterilization Procedures’, p. 77.
\textsuperscript{49} World Health Organization, Female Sterilisation, pp. 16-7, 106.
\textsuperscript{50} Interview with Deborah Fielding\textsuperscript{*} by Tiarne Barratt, 23 April 2014.
\textsuperscript{51} Interview with Ian Stewart, 26 November 2013.
\textsuperscript{52} Clyman, ‘Tubal Sterilization by Operative Culdoscopy’, pp. 4-5; Peel and Potts, Textbook of Contraceptive Practice, p. 158.
\textsuperscript{53} Ross et al., Voluntary Sterilization, pp. 34-5.
\end{footnotes}
a simple outpatient female sterilisation procedure. Though laparoscopy was gaining
popularity at the same time, minilaparotomy was a far less complicated procedure and in
contrast to the specialist training required for laparoscopic surgery, it could be performed
by doctors with basic surgical skill or by trained paramedics.\textsuperscript{54} Minilaparotomy was easier
to perform than laparoscopy, easier to teach, and easier to learn, which made it popular
with family planning programs in developing countries in the 1970s and ‘80s.\textsuperscript{55} In
addition, it could be performed at any time, including postpartum and post-abortion
sterilisations, whereas the resulting enlarged fallopian tubes acted as a contraindication for
laparoscopic technology.\textsuperscript{56} Minilaparotomy had all the benefits of open abdominal surgery,
with lower rates of infection, postoperative pain, and recovery time, yet it was a more
invasive procedure than laparoscopic sterilisation. The introduction of laparoscopic
surgical technology in the latter half of the twentieth century signified a huge milestone in
the history of female sterilisation procedures. The laparoscope meant that sterilisation no
longer required open abdominal surgery, but could instead be achieved through minimally
invasive “keyhole” surgery.\textsuperscript{57} In contrast to traditional abdominal surgery, laparoscopic
surgery was performed through small incisions in the abdominal wall. This enabled
complex operations to be performed with minimal operating time and without the lengthy
and difficult recovery that was often associated with traditional open surgery. Laparoscopy
relied on the transmission of light down the tube of the scope into the abdomen, so that
surgeons could see internally without the need for large incisions. Specialised accessory
instruments were then used to carry out surgery via the sheath of the scope, of which

\textsuperscript{54} Rustom P. Soonawala, ‘Minilaparotomy Sterilization’, in Dirk A.F. van Lith, Louis G. Keith, and E.V. van
\textsuperscript{55} Soonawala, ‘Minilaparotomy Sterilization’, p. 129.
\textsuperscript{56} EngenderHealth, \textit{Minilaparotomy for Female Sterilization: An Illustrated Guide for Service Providers}
\textsuperscript{57} Zetka Jr., \textit{Surgeons and the Scope}, p. 1; Patrick C. Steptoe, \textit{Laparoscopy in Gynaecology} (Edinburgh and
microelectrodes were the most significant in initial tubal ligation procedures. This new laparoscopic technology separated surgeons’ eyes from their hands, and it required very different hand-eye coordination skills to open surgery, which were not necessarily easily transferable and caused some doctors to resist this new technology in favour of minilaparotomy.

For Stefania Siedlecky, the development of laparoscopic technology was the most significant change in her practice performing female sterilisation. She outlined her personal and professional experience with open abdominal surgery compared to minimally invasive surgery:

**Tiarne Barratt:** And in terms of the operation itself [tubal ligation], how did that change?

**Stefania Siedlecky:** Well we used to do a big cut down the middle and tie the tubes up. We later discovered that we could put a little instrument in there [a laparoscope], you know a keyhole instrument, and cut the tube through that – much simpler.

**TB:** So when you started doing sterilisations, you were doing the big cut operation [laparotomy]?

**SS:** Yes, (laughter) they were a terrible operation.

**TB:** In what way?

**SS:** Well, great big hole, I must say, I’ve got one myself because I had the hysterectomy through there. But it was this great big cut and took a couple of weeks to heal.

**TB:** So it was quite painful?

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58 The design of early laparoscopes meant that surgeons were required to physically look down the shaft of the scope in order to see the operating site. In the 1980s and ‘90s, advancements in video technology meant that miniature cameras could be attached to the scope, which facilitated the display of live video footage on television monitors, and enabled surgeons to instead view the operating site on large screens; Wood, *Vasectomy and Sterilization*, pp. 42-3; Zetka, *Surgeons and the Scope*, p. 1.
SS: Oh yes, quite uncomfortable, and so the more modern surgery [laparoscopy] didn’t have that kind of pain.59

The laparoscope minimised both operating and recovery time, which meant that there was a huge demand for this kind of surgery at an organisational and individual level.60 Some gynaecological historians have attributed the initial widespread uptake of laparoscopy to a combination of the “sexual revolution” and legal reforms in the United States that took place throughout the 1960s.61 However ideas of visual technology within sterilisation were the subject of experimentation within private organisations throughout Europe as early as the 1950s, and contrary to popular opinion, the advent of laparoscopy did not influence patients’ decisions to undergo sterilisation, only doctors’ decisions to perform tubal ligation in contraceptive circumstances.62 By the 1970s, laparoscopic surgery had begun to be widely employed in the field of female sterilisation: the introduction of the laparoscope shaped Ian Stewart’s career in tubal ligation and he operated with this technology for the majority of his practice. Stewart was introduced to laparoscopy in 1969 while training as an obstetrician at the Royal Prince Alfred Hospital in Sydney. Following this, he took up a residency position in England in 1971 at a hospital that had begun to use laparoscopic technology extensively, and it was here that he learnt how to perform tubal ligations using the laparoscope. Upon his return to Sydney in 1974, Stewart was offered a gynecological position in Wagga Wagga, NSW, where as a valued member of staff he was provided with expensive laparoscopic equipment. The laparoscope promised surgical efficiency and

59 Interview with Stefania Siedlecky, 2 September 2013.
outpatient abdominal surgery – for Stewart, laparoscopy was the future of female sterilisation.

When laparoscopic technology was first developed, electrocautery was the only compatible method of tubal occlusion: electrocautery, or electrocoagulation, refers to electrical methods of sterilisation. Introduced in the early twentieth century, electrocautery was initially pursued in an effort to prevent recanalisation of the fallopian tubes, and was originally designed to be used in conjunction with a transvaginal approach in order to avoid a physically demanding abdominal procedure. In the first half of the twentieth century, medical opinion regarding the benefits of sterilisation via electrocautery was varied, ranging from gynaecologists who felt the technique had little to recommend itself, to those who saw it as ‘the simplest of all sterilisation procedures’. Within Australia, it was widely used, yet memories of electrocautery are characterised by the potential side effects that this method produced: electrocautery ran the risk of accidentally burning internal organs and although Stewart used this method in the first years of his laparoscopic practice, it was with reservations and he replaced it with mechanical occlusion devices as soon as they became available. Vasectomy specialist Barbara Simcock, retained strong views on the damaging nature of electrocautery, as she believed that the burning of the fallopian tubes caused long term ovarian damage and heavy periods. Overall, the success of electrocautery was heavily dependent upon gynaecologists being able to adequately view the fallopian tubes in order to prevent accidental internal burns, and the rise of laparoscopic technology led to a surge in the popularity of electrocoagulation in the

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63 Interview with Ian Stewart, 26 November 2013.
65 Dickinson and Gamble, Human Sterilization, p. 19; Ellison et al., Sex Ethics, p. 247.
66 Interview with Ian Stewart, 26 November 2013.
67 Interview with Dr Barbara Simcock by Tiarne Barratt, 24 July 2013.
1970s. As the demand for electrocautery increased, there was an attempt to produce a technique that would reduce burns complications, and by the early 1980s the original unipolar coagulation technique was replaced with a bipolar coagulation technique that gave the operator more control over the electrical current. Within unipolar coagulation the electrical current ran from the forceps to a ground plate on the thigh of the patient, meaning that the current had to pass through the patient and any tissue that was touched was burnt. Bipolar coagulation meant that the current only flowed between the two prongs of the forceps, eliminating possibilities for accidental burns as the coagulation zone became more limited. Yet despite advances in the safety of electrocautery, by the 1980s mechanical occlusion devices such as bands and clips had come to dominate the surgical market.

As early as the 1960s, gynaecologists began experimenting with mechanical occlusion devices that would utilise new laparoscopic technology without the side effects associated with electrocoagulation. By the early 1970s, a multitude of mechanical devices in the form of silastic bands and clips were in the process of human trials, and soon entered surgical practice, the most popular of which were the Falope or Yoon ring, the Hulka clip, and the Filshie clip – all still in use in the twenty-first century. The Falope ring was designed by Dr Inbae Yoon and introduced in 1972. The band consisted of a tubal

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69 Ross et al., *Voluntary Sterilization*, p. 35; van Lith, ‘Coagulation by the Semm and Wolf Techniques’, p. 61.
72 EngenderHealth, *Contraceptive Sterilization*, pp. 141-4; There have been more recent technological developments, yet none which have reached the same level of widespread use as these mechanical devices developed in the 1970s.
ring made out of silicone rubber, which was applied to a looped section of the fallopian tube, comparable to the Pomeroy technique in the looping process. The Falope ring could be applied using a variety of approaches – laparoscopy, minilaparotomy, or transvaginal – it could be performed as an outpatient procedure, and it had an extremely high success rate. By 1975 the device had been tested in the US, the Philippines and South Korea with no reports of major complications or pregnancy, after which the technique spread throughout the developing world via family planning programs. However, the Falope ring was associated with high levels of postoperative discomfort and tubal damage, it was difficult to use in postpartum or post-abortion sterilisations, and it was eventually surpassed in popularity by other mechanical devices, namely clips. Clips represent the largest group of mechanical occlusion devices used in female sterilisation procedures. Experimentation began in the late 1960s and early design goals focused on finding a clip that would sufficiently occlude the tubes without completely damaging them, in order to facilitate reversible sterilisation – all of which were integral to the increased availability of contraceptive tubal ligation as technology became safer, more effective, and more readily reversible.

A design known as the Hulka clip was the first clip to achieve large-scale international success within tubal ligation procedures. Used by many Australian doctors throughout the 1970s, the Hulka clip was one of the most widely applied methods of occlusion of the twentieth century. The Hulka clip is a small spring-loaded clip that was developed by Dr Jaroslav Hulka at the University of North Carolina. It is applied to the

75 Ross et al., Voluntary Sterilization, p. 35.
76 Wood, Vasectomy and Sterilization, p. 127.
77 Interview with Ian Stewart, 26 November 2013; Interview with Barbara Simcock, 24 July 2013.
fallopian tubes laparoscopically, and works by compressing approximately 3mm of the tube to bring about occlusion, which damages considerably less than the 2-3cm of tissue associated with silastic bands and traditional methods of excision and division.\textsuperscript{78} Animal studies of the Hulka clip began in 1971, progressed to the first human sterilisation in 1972, and then to large-scale human trials in 1973. In 1975, Hulka issued a patent for the device, and by 1976 had declared the experimental phase of the clip over: it had by that point become a standardised method of sterilisation, despite early design flaws that produced high failure rates and potential for ectopic pregnancy.\textsuperscript{79} With the success of Hulka clips, advances in mechanical occlusion devices flourished, and in the early 1980s the Filshie clip was introduced to the global market.\textsuperscript{80} The Filshie is a titanium clip lined with silicone rubber: as the clip closes, both the fallopian tube and the silicone are compressed, then, as the tube shrinks and undergoes the process of necrosis (death of body tissue), the compressed rubber expands and fills the gap in order to prevent recanalisation of the tubes.\textsuperscript{81} G. Marcus Filshie developed the device in the United Kingdom in conjunction with Donn Casey, then chairman of the Simon Population Trust. The Filshie clip had the advantage of being able to accommodate enlarged tubes, making it an ideal candidate for postpartum and post-abortion sterilisations, as it could be applied via laparoscopy or minilaparotomy.\textsuperscript{82} After a series of trials and modifications throughout the 1970s, the Filshie clip became a widespread method of tubal occlusion in the 1980s.\textsuperscript{83} Amongst

\textsuperscript{78} Hulka et al., ‘Spring Clip Sterilization’, p. 1039; Brian A. Lieberman, ‘The Hulka Clemens Clip’, in van Lith et al., eds., New Trends in Female Sterilization, p. 105; Ross et al., Voluntary Sterilization, p. 35.
\textsuperscript{80} Ross et al., Voluntary Sterilization, p. 35.
Australian doctors, Ian Stewart swapped the Hulka for the Filshie clip when it became available, believing it to be a superior method: however he did recall that in its early years, it was known to gradually sever the tubes, resulting in the clip detaching and becoming loose in the pelvis. While this was not a serious complication, it does reveal the pace at which experimental female sterilisation technology was picked up throughout the twentieth century and the ongoing process of development and improvement that this technology witnessed. Within the history of contraceptive sterilisation, technology and public opinion were mutually perpetuating factors in the process of normalisation and dissemination that took place throughout the twentieth century. Although female sterilisation technology has moved towards endocrinology and hormone treatment since the end of the twentieth century, a large number of the techniques outlined here remain in use in twenty-first century Australian practice.84

The Surgical History of Vasectomy

Vasectomy is the operation used to achieve male sterility. It is a simple outpatient surgical procedure that involves occluding the vas deferens (the tubes that carry sperm, commonly known as the vas or vasa) so that when a man ejaculates, it no longer contains any sperm and this prevents the possibility of conception occurring.85 Unlike the complex surgical characteristic of tubal ligation, vasectomy is a simple procedure – in the words of Australian vasectomy pioneer Dr Barbara Simcock, ‘…it’s not brain surgery!’86 The procedure consists of locating the vas deferens through a small scrotal incision under local anaesthetic, followed by occlusion of the vas via ligation, division, excision, or cauterisation. Although techniques of occlusion used in vasectomy are similar to those

86 Interview with Barbara Simcock, 24 July 2013.
used in female sterilisation, the easily accessible location of the vas eliminates the need for complicated abdominal surgery – a consistent technological barrier to minimally invasive tubal ligation. Instead, access to the vas requires only a small scrotal opening, which is done via a double incision on either side of the scrotum, or a single incision in the middle through which both vasa are reached. Double incision is the traditional method of approach, and it has been used consistently from the nineteenth to the twenty-first century. This simplicity has meant that in terms of surgical technique, vasectomy practices have not altered dramatically since the operation was first conceived of in the nineteenth century, and throughout the twentieth century practices were often contingent on geographical location, resources available, and the skill, knowledge and training of the practitioner – the procedure could be personalised depending on the surgeon’s preferred operating style. For this reason, there are fewer opportunities to examine major technological developments in the surgical history of vasectomy compared to the surgical history of tubal ligation and this narrative will incorporate more from the experiences of individual Australian doctors in order to study different operating techniques, styles, and the impact of hegemonic masculinity.

Throughout the twentieth century vasectomy techniques did not follow a clear timeline as practices overlapped and changed depending on the surgeon. Medical opinion regarding the ideal method of occlusion has never been comprehensive and much of this

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discussion has remained unofficial and unpublished. For example, prior to commencing her own vasectomy career, Barbara Simcock observed two private Sydney vasectomy practitioners in 1971 – she recalled being shocked by the contrast in their operating technique. The first was a suburban GP performing so many vasectomies that he was running ‘his own mini clinic’. The procedure was done under local anaesthetic, took approximately twenty minutes, and Simcock was impressed by his efficient and gentle technique and patients’ fast recovery time. The second doctor was an inner city surgeon performing vasectomies under general anaesthetic in a private hospital that required an overnight stay. Simcock described him as a “butcher”; his technique was rough, involving large double ‘slashes’ to the scrotum, profuse bleeding, bruising and swelling – over forty years later, she remained appalled by the memory of watching this man operate. Both doctors performed successful vasectomies, with different techniques and never published the results. This example reveals that disparity in technique could occur even within the same city, and experiences of vasectomy were entirely dependent on the context and the operating doctor. This meant that individuals such as Simcock and Errey were in a position to make a unique contribution to the history of vasectomy practice in Australia: they were responsible for innovative developments in technique and operating style and this meant that vasectomy practice often had a more personal element to it than the comparative anonymity of gynaecological surgery.

In 2011, the United Nations Department of Economic and Social Affairs (Population Division) revealed that worldwide, 19% of women aged 15-49 who were married or in a union reported that they currently relied on female sterilisation for protection against unwanted pregnancy – making tubal ligation the most popular method.

89 Interview with Barbara Simcock, 24 July 2013.
of contraception in the world.\textsuperscript{90} In comparison, 3\% of women in this focus group reported use of vasectomy.\textsuperscript{91} Although these statistics are not comprehensive, they are indicative of the general trend in attitudes towards male and female sterilisation that have existed since the nineteenth century: tubal ligation, the more expensive, time consuming, and invasive procedure is highly favoured, while vasectomy, a comparatively simple, inexpensive and minimally invasive procedure, is one of the least used methods of contraception. The reason behind this enduring attitude is vasectomy’s entrenched association with castration and the ensuing complex relationship with masculinity that this connection has created.\textsuperscript{92}

Both in Australia and worldwide, castration has remained one of the most significant factors in discussion of vasectomy well into the twenty-first century, and masculinity is inextricably woven into the surgical history of vasectomy.\textsuperscript{93} As a result, tubal ligation was consistently and significantly more popular than vasectomy throughout the twentieth century, with the exception of the unprecedented rates of vasectomy witnessed in India during the Emergency Period of the 1970s.\textsuperscript{94} Like tubal ligation, the surgical origins of vasectomy began in the nineteenth century, however the primary purpose of experimentation during this period was to ensure that vasectomy was infinitely different to castration – work that largely took place on animals rather than humans. In glaring contrast, ovariotomy (female castration) was employed frequently throughout this period,

\begin{itemize}
\item Note: contraceptive statistics are universally recorded through women in long term heterosexual relationships and these numbers serve as a guide rather than a definitive overview.
\item \textsuperscript{91} Because contraceptive statistics are recorded through female usage, first hand data for male usage is not available.
\end{itemize}
often with little concern as to the side effects of the operation and the onset of premature menopause that it caused.\textsuperscript{95} Ironically, the prevalence of female castration led to advances in gynaecological surgery that facilitated increased medical acceptance of tubal ligation, whereas enduring fears of male castration have been the single biggest deterrent to the uptake of contraceptive vasectomy and account for the ongoing disparity in male and female sterilisation practices.

Mid-twentieth century histories of vasectomy frequently begin with an account of Astley Cooper’s experimental work relating to vassal occlusion in dogs in London in the 1820s.\textsuperscript{96} This particular experiment was hailed as historically significant in the 1960s and ‘70s – when contraceptive vasectomy was becoming increasingly popular – in an attempt to alleviate anxieties based on the widespread belief that vasectomy was akin to castration. Cooper set out to observe the comparative effects of castration and vasectomy by ligating the spermatic cord on one side of a dog’s testes, and the vas on the other side. The results revealed that, unlike the physically harmful procedure of castration, vasectomy left the subject with full sexual capacity, no adverse side effects, and rendered him sterile without affecting his capability for sperm production.\textsuperscript{97} Because it was deemed necessary to understand the parameters and potential side effects of ligating the vas prior to human


\textsuperscript{97} Wolfers and Wolfers, Vasectomy and Vasectomania, pp. 12-3.
vasectomy experimentation, the animal experimentation that Cooper began was continued in France by P. Gosselin and E. Brissaud, respectively working in the 1840s and the 1880s. Their experimentation revealed that it took several months for ligation of the vas to have a sterilising effect, and verified that sperm production continued as normal after ligation or excision of the vas. This research confirmed that vasectomy and castration were entirely different operations, and that vasectomy was a simple procedure that did not interfere with a man’s sexual capacity or result in any damaging side effects – yet the stigma of castration and the idea of vasectomy as punishment lingered. In 1903 British doctor J. Lynn Thomas was approached by a patient who had had his ‘vasa deferentia tampered with’, in short the man had been vasectomised, but not by a doctor. Further questioning revealed that the man’s wife had performed the vasectomy ‘during a fit of jealousy… with a surgical knife while the patient was in a state of advanced semi-comatose intoxication’, under the misapprehension that severing the vasa would have the effect of castration and lead to lifetime of sexual impotence. Although the woman later regretted the operation, her actions reveal an intent to punish via vasectomy as one would with castration that is indicative of the public perception of vasectomy in the early twentieth century.

The idea of vasectomy as punishment is one that stems from the history of castration as punishment and the perceived confusion that equates these two operations. This confusion was perpetuated by the work of Harry C. Sharp, chief physician of the Indiana State Reformatory, who began to perform vasectomies on inmates under his care in 1899. In this context, Sharp’s contemporaries performed castration to sterilise inmates and he presented vasectomy as a favourable move away from this practice, as vasectomy

Although Sharp believed that his actions ‘absolutely [did] not… place restrictions, and therefore punishment, on the subject’, he was working within the realm of a penal institution, meaning that his patients could not provide consent, and that his actions constituted punishment irrespective of the lack of side effects experienced. For those uninitiated to the surgical technique of these operations, the difference between vasectomy and castration would not have been readily apparent and in the context of reform facilities, for many they were interchangeable regardless. Around the turn of the twentieth century, A.J. Ochsner – Sharp’s contemporary and a practitioner of clinical vasectomy who later became president of the American Medical Association – began to recommend that vasectomy be applied to ‘criminals, degenerates and perverts’ in order to prevent them from reproducing. Together, Sharp and Ochsner have been hailed by urologists as pioneering practitioners of eugenic sterilisation, and their vision to sterilise inmates and those considered “degenerate” was a popular one. Eugenic sterilisation was the first context in which sterilisation was a widely discussed public phenomenon: this concept held currency for several decades in the twentieth century, and the early history of institutionalised vasectomy practice cast a far reaching shadow over the procedure.

Public perception of vasectomy in the early twentieth century was complex and contradictory: running parallel to the idea of vasectomy as punishment, was the idea of vasectomy as rejuvenation. Largely attributed to the work of Austrian physiologist, Eugen Steinach, rejuvenation referred to unilateral (one sided), open-ended vasectomy, where the

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end of the vas closest to the testes was left open in an attempt to increase masculine vitality via the reabsorption of sperm.\textsuperscript{104} The aim of this operation was not to sterilise, but to “rejuvenate” the patient mentally, physically, and sexually, by delaying the onset of old age and senility. Norman Haire was an internationally renowned proponent of rejuvenating vasectomy, indeed it was his work with vasectomy that led to his fame.\textsuperscript{105} Haire became aware of the perceived rejuvenating properties of the procedure in 1921 and remained a strong advocate and practitioner of rejuvenation in subsequent decades.\textsuperscript{106} Prior to this Haire had practised vasectomy in cases where he felt it would be eugenically beneficial, and believed the operation to be an ‘easy and harmless method of rendering men infertile without diminishing their sexual desire and potency’.\textsuperscript{107} He recommended a technique of bilateral ligation, division and excision, and believed this to be the most effective way to perform the procedure when the intent was to sterilise rather than “rejuvenate”.\textsuperscript{108}

In the male, a small incision is made on each side of the scrotum, the spermatic cord is drawn out, and the sperm duct or vas deferens carefully separated from the other structures which form the spermatic cord. The sperm duct, thus carefully separated, is ligatured in two places, about an inch apart, with both silk and catgut, and the intervening length is cut out... The various layers of tissues, which have been divided to expose the sperm duct, are reunited, and the skin stitched with silk-worm gut.\textsuperscript{109}

Unlike many of his contemporaries, Haire did not approve of vasectomy being performed in doctors’ surgeries under local anaesthetic: he recommended general anaesthetic and two

\textsuperscript{107} Haire, \textit{Rejuvenation}, p. 10.
\textsuperscript{108} Haire, “Sex Education – Sex and the Individual”, NHC.
to three day’s hospitalisation, and this is an example of the potential for personalisation and individual preference within the surgical application of vasectomy.\textsuperscript{110} However for all his work with rejuvenation, Haire was not a proponent of contraceptive sterilisation and only condoned this practice in therapeutic, eugenic, or “rejuvenating” circumstances.\textsuperscript{111}

Victor Hugo Wallace began performing vasectomies in his private practice in Melbourne in 1934, and differed from Haire in both surgical technique and personal views: Wallace readily performed contraceptive vasectomies, and never viewed the procedure as anything but basic outpatient day surgery. Upon commencing his vasectomy practice, Wallace began to experiment with a variety of techniques until he found what he thought to be the optimum method of occlusion. In early operations, he applied local anaesthetic and ligated and divided the vas through a double scrotal incision. By the early 1940s he had decided that the procedure would be more effective if he removed a quarter-inch section of the vas on either side, in addition to ligation of the ends.\textsuperscript{112} Over the course of the 1950s, Wallace began to perform an increasing number of vasectomies and gradually increased the size of the section of the vas that he removed. By the 1960s he believed that the most effective vasectomy was achieved by crushing the tubes with Spencer Wells forceps, followed by ligation and removal of a full inch of the vas on either side.\textsuperscript{113} While this technique would certainly have been effective in bringing about permanent sterility by preventing the possibility of recanalisation, it would have made reversing the operation difficult. In this regard, Wallace was operating with a different mind-set to the new generation of vasectomy doctors that began practising in the late 1960s and early 1970s,

\textsuperscript{110} Terriss, ‘A Doctor Looks at Life – Sterilisation Queries’, NHC.
\textsuperscript{111} Haire, ‘Sex Education – Sex and the Individual’, p. 14, NHC.
\textsuperscript{112} ‘Patient History Cards’, Box 63, Victor Hugo Wallace Collection, University of Melbourne Archives [hereafter VHWC].
for whom reversibility was as important as effectiveness.\textsuperscript{114} This desire for reversible techniques was not strictly associated with the second half of the twentieth century, but it was popularised in this context. For example, in the 1930s American doctor J.E. Strode was concerned with preventing recanalisation as well as facilitating reversal and recommended burying or anchoring the ligated ends of the vas into surrounding tissue to achieve this.\textsuperscript{115} But it was not until contraceptive sterilisation became more popular in the latter half of the twentieth century that reversal technology was prioritised and improved, demonstrated by the uptake of microsurgery in Australia in the early 1970s, of which Sydney surgeon Earl Owen was a pioneer.\textsuperscript{116}

In the United States in 1950, Robert Latou Dickinson and Clarence James Gamble published \textit{Human Sterilization}, a survey of all known male and female sterilisation techniques. This text acted as a source of surgical information on sterilisation and listed all possible methods of vasectomy approach and occlusion, providing an excellent example of the simplicity and multiplicity of the procedure.\textsuperscript{117} Born in 1894, Gamble was one of the most vocal advocates of sterilisation in early twentieth century America. After obtaining a medical degree from Harvard University in 1920, Gamble became increasingly engaged with the eugenics movement and committed significant time and financial resources to providing poor, uneducated, and “mentally deficient” women with contraception. By the 1940s his interests had progressed from reversible contraception to sterilisation and he founded more than twenty sterilisation clinics in Midwest and South America, in addition to dozens of birth control clinics, in which thousands of Americans were subject to

\begin{footnotes}
\item[114] Interview with Barbara Simcock, 24 July 2013; Interview with Dr Bruce Errey by Tiarne Barratt, 15 January 2014.
\item[117] See Figure 1.3; Dickinson and Gamble, \textit{Human Sterilization}, pp. 24-6.
\end{footnotes}
involuntary sterilisation. Dickinson too was an advocate of eugenic sterilisation, but he was also an early advocate of the separation of sex and reproduction and in the 1920s promoted sexual satisfaction as the key to marital happiness. He later became the Senior Vice President of the Planned Parenthood Federation of America and played a key role in changing public attitudes towards birth control in the twentieth century – his influence akin to that of Margaret Sanger. \(^{119}\) *Human Sterilization* draws attention to the neutrality of surgical technology: both Dickinson and Gamble had an active interest in eugenic sterilisation, yet this text exists outside the classification of coercive or voluntary that so often characterises analysis of the history of sterilisation. Because its focus was purely technical, the broader socio-political context of global sterilisation debates was absent and the surgical technology that dictated sterilisation practice became apparent – it illuminates sterilisation from a strictly medical perspective.

In 1950 the majority of vasectomy procedures were conducted via the traditional double incision method, yet in *Human Sterilization* Dickinson and Gamble introduced the concept of single incision vasectomy, first developed in the late 1940s. \(^{120}\) The single incision method was popularised through Indian family planning programs in the 1960s and ‘70s, favoured in this context because it was time efficient and did not require external sutures that would need to be removed in follow-up appointment. \(^{121}\) Practitioners of this technique employed a scalpel to stab a small hole in the middle of the scrotum, through which the vasa could be accessed and ligated: done this way the procedure took Indian doctors approximately three minutes and patients could return to work immediately. \(^{122}\) Barbara Simcock introduced Indian single incision vasectomy to Australia in the early

\(^{118}\) Dowbiggin, *The Sterilization Movement*, pp. 49-53.


\(^{120}\) Dickinson and Gamble, *Human Sterilization*, p. 25.

\(^{121}\) Sheynkin, ‘History of Vasectomy’, p. 291.

\(^{122}\) Interview with Barbara Simcock, 24 July 2013.
1970s. In 1972 she spent two weeks in India with local Family Planning doctors, where she learnt how to perform vasectomies using the single incision approach. Simcock used this technique in her practice at the Family Planning vasectomy clinic in Sydney for several years, until she met American vasectomist Stanwood Schmidt and took up his method of coagulation of the vas via microelectrodes and continued to practice this technique until the electrodes required became difficult to access in the late 1980s.123

Within the Schmidt technique, a needle electrode was inserted into the lumen (cavity) of the vas, which destroyed two to three millimetres of the tube. The vas was then divided and a barrier of fascia (fibrous tissue) placed between the cut ends of the tube using the sheath of the vas.124 Schmidt developed this technique because he felt that traditional ligation and excision techniques unnecessarily mutilated the vas, were superfluous to the overall success of the procedure, and made reversal needlessly difficult. As with all vasectomy techniques, it was highly personalised: its dissemination was largely dependent upon Schmidt himself and with the exception of some Canadian vasectomy clinics, “Schmidt” is no longer in circulation.125

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123 Interview with Barbara Simcock, 24 July 2013; Interview with Bruce Errey, 15 January 2014.
Figure 1.4: Bruce Errey, ‘Pre and Post Op Notes on Vasectomy’, (n.d. 1970-9), in Bruce Errey private collection.
Bruce Errey began performing vasectomies in Brisbane in 1970 after receiving minimal informal instruction on the required surgical technique – the procedure was described to him over the phone by a colleague in Sydney. This colleague was the same GP who was involved in Simcock’s initial vasectomy training, and although he did not wish to be interviewed or personally identified in this research, he had a significant impact on the surgical history of vasectomy in Australia and unofficially trained many doctors new to the profession. During the first nine years of his practice (1970-9) Errey removed an inch of the vas, turned the ends back and cauterised them, then put a stitch through each end to keep them in place.\(^{126}\) In 1979 Errey adjusted his technique as a result of the postoperative discomfort that some of his patients reported experiencing. To counteract this pain he began using an open-ended technique, meaning that he divided the vas, but only cauterised one side.\(^{127}\) This was followed by a series of subtle changes made over following decades, yet overall Errey remained fairly traditional in his surgical approach. In contrast, Simcock continued to pursue the latest technology and travelled to Thailand in 1990 to learn the technique of No-Scalpel Vasectomy (NSV) from Chinese doctors. In NSV, both vasa are occluded via a single puncture hole, so small that it is barely visible after the operation and does not require sutures. This technique requires specialised tools in the form of a micro vas clamp and a pair of specially designed forceps that are used to pierce the skin as well as ligate the vas.\(^{128}\) The uptake of NSV in the mid-1980s represents one of the few significant technological developments within the surgical history of vasectomy. NSV was developed in China in 1974 by Dr Shunqiang Li, but was unheard of outside China until the mid-1980s when a medical team from the Association for

\(^{126}\) See Figure 1.4; Bruce Errey, ‘6,367 Vasectomies’, *Bulletin of the Post-Graduate Committee in Medicine, University of Sydney* (November 1977), in Bruce Errey Private Collection [hereafter BEPC], accessed January 2014.

\(^{127}\) Interview with Bruce Errey, 15 January 2014.

\(^{128}\) Interview with Barbara Simcock, 24 July 2013.
Voluntary Surgical Contraception were invited to observe and receive training on the technique.\textsuperscript{129} According to Li, NSV was the ‘least traumatic’ technique available and its introduction made vasectomy ‘safer, easier, and more effective’.\textsuperscript{130} NSV remained Simcock’s preferred operating technique and her career demonstrates the international nature of vasectomy practice, as her operating style was regularly influenced by doctors from around the world. This technique has been consistently popular outside of China since 1985 due to its minimally invasive nature and reduced operating time, yet even so, conventional double incision vasectomy is still widely practised and advocated.\textsuperscript{131}

Over the course of the twentieth century, vasectomy served a number of purposes: it was a punishment, a eugenic solution, a method of “rejuvenation”, and a reasonably popular contraceptive. A commonality within these various applications of vasectomy technology was a complex, often contradictory relationship with masculinity, as vasectomy was perceived to both threaten, and paradoxically reinforce, the patients’ masculinity. On one level, it has represented a loss of manhood by stripping a man of his reproductive potential and sexual virility. Yet vasectomy has been equally thought to both “rejuvenate” and “prove” a man’s masculinity by facing the fear of castration, representing the ultimate sacrifice in order to protect partners from further pregnancy.\textsuperscript{132} This relationship with masculinity has not only had an impact on patients, but also on doctors’ practices of vasectomy. For example, Simcock explained that she began every consultation by explaining the difference between castration and vasectomy in an attempt to alleviate ever present fears of castration. ‘…the first thing you have to say [is] that is doesn’t affect

\textsuperscript{129} D. Huber, ‘No-Scalpel Vasectomy: The Transfer of a Refined Surgical Technique from China to Other Countries’, \textit{Advances in Contraception} vol. 5 (1989), p. 217.
\textsuperscript{132} Greenfield and Burrus, \textit{The Complete Reference Book on Vasectomy}, p. 19.
your testicles, we’re not touching your hormones, nor your blood supply to your testicles… [because] no man wants to be castrated’. Her serious consideration regarding the subject of masculinity was appreciated, demonstrated in a letter that Simcock received from a former patient in 1992, in which the man thanked her for making a potentially traumatising experience pleasant. However the influence of “masculinity” on vasectomy practice is no more apparent than in the career of Bruce Errey.

As a man who has undergone a vasectomy, as well as performed the operation over 30,000 times, Bruce Errey is a man with an intriguing relationship to masculinity and vasectomy, characterised by his feelings towards homosexuality. As a result of the gay liberation movement, homosexuality was a normalised, albeit controversial, aspect of the political landscape in Australia by the late 1970s, demonstrated in the gradual decriminalisation of homosexuality. However the homophobia of previous decades was not so quickly dispelled, and Errey’s preoccupation with masculinity and vasectomy was a relic of 1950s understandings of homosexuality and masculinity, in which homosexuality was perceived as a threat that required suppression, lest it jeopardise the stability of heterosexual masculinity. Errey felt that it was his duty to discover homosexual clients, effeminate clients, and clients whose wives had pressured them into the operation, and after two decades of general practice, he felt that he was a fairly good judge, although ‘there’d be a few exceptional ones where I’ve been hoodwinked by a patient, or wasn’t alert enough to subtle indications.’

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133 Interview with Barbara Simcock, 24 July 2013.
134 Interview with Barbara Simcock, 24 July 2013.
137 Interview with Bruce Errey, 15 January 2014.
observing Errey’s vasectomy clinic in the late 1970s noticed his unusual attitude towards masculinity:

**Petah Digby**: Why do you ask the names of the children, along with their age [during a vasectomy consultation]?

**Bruce Errey**: It’s polite and they seem to be able to think better at that level (“first born, name? How old? – Karen, 12; John, 10 and so on…”) Wives are better at this. Sometimes husbands join in, or they discuss it together…

**PD analysis**: This is one way in which the doctor claims to be able to weigh up the “masculinity” of the candidate. The implication is that if he had too great a command of the details of the children’s date of birth or of the couples’ contraceptive/obstetric history, he might be less the “wearer of the pants”. 138

Throughout his forty years of practice, his patient’s relationship to what he termed ‘masculinity’ was extremely important to Errey and determined his decision to take them on as clients. He had a stipulation that his patients must have recently been engaged in a heterosexual relationship, and he would not perform vasectomies on homosexual or bisexual men due to a belief that there was an imbalance in their “masculinity” and vasectomy would cause further psychological damage. 139 Similarly, any man who did not pass Errey’s personal “masculinity” test – failed by exhibiting signs of perceived effeminacy – would be required to submit to a second consultation and “prove” their heterosexuality before he would consent to perform the operation. 140 When questioned about this aspect of his practice, Errey had difficulty putting his reasons for his


139 Although there was much medical concern in the 1970s about the adverse psychological effects of vasectomy if the patient was uncomfortable with the idea of his genitalia being surgically interfered with, there was no such consensus that an absence of “masculinity” would result in psychological trauma; ‘Who Does Vasectomy – Correspondence’, *The Medical Journal of Australia* vol. 1, no. 14 and no. 20 (1973), pp. 549-50, 812; Interview with Bruce Errey, 15 January 2014; Interview with Barbara Simcock, 24 July 2014; Interview with Jessica Henson* by Tiarne Barratt, 14 January 2014; Petah Digby, ‘Regretted Male Sterilisation’, unpublished paper, 1981, BEPC.

140 Interview with Bruce Errey, 15 January 2014; Vasectomy patient records from BEPC.
preoccupation with patients’ masculinity into words – which is more revealing than if he had been able to explain it, as this demonstrates an ingrained perception of vasectomy as inextricably linked to ideas of manhood. Simcock had patients whom she refused to sterilise on the grounds that she did not believe them to be stable enough to make such a permanent decision, yet as a female doctor she did not display the same level of personal involvement in such cases as Errey. Haire, Wallace, Simock and Errey were four key examples of Australian vasectomy practitioners in the twentieth century. Though they all employed different operating techniques, their experiences are indicative of the surgical history of vasectomy, which is by nature simple and open to personal interpretation.

Conclusion

Within the arena of reproductive healthcare, the idea of contested authority within doctor/patient relationships is a classic example of the welding of knowledge, power and authority.141 As a result, an everyday need for fertility control often becomes an exercise in public navigation rather than private choice, in which it is doctors who have the authority to dictate the form of the exchange. Throughout the twentieth century, the practice of surgical contraception has provoked a continuing struggle between doctor and patient authority when it comes to individuals’ access to sterilisation procedures. Each party claims a unique knowledge, either of their personal reproductive needs and choices, or of the surgical procedures required to realise these choices, and the issue of contested authority has created distinct obstacles for those seeking permanent contraception, with patients repeatedly having to prove themselves by meeting a series of requirements relating to age, health, marital status and parity, imposed by the medical profession.

Throughout the twentieth century, individual doctors acted as the gatekeepers of contraceptive sterilisation, determining when, why and who could access these procedures. Elevated to this status by their exclusive medical knowledge and surgical training, doctors acted as an unofficial governing body, operating on a set of internally determined and upheld rules that were then passed on and continued by following generations of medical professionals. For this reason, the surgical history of sterilisation is important because technology determined medical attitudes, and the subsequent contraceptive availability of these procedures. As sterilisation became easier, quicker and cheaper; as rates of success increased; and as the possibility of side-effects and medical complication decreased, more doctors were willing to perform these procedures and more patients developed the confidence to request them. This facilitated increased knowledge and discussion of contraceptive sterilisation, which continued throughout the twentieth century until tubal ligation and vasectomy became readily available by the 1980s.

As demonstrated throughout this chapter, the medical acceptance of female sterilisation was tied to developments in methods of tubal occlusion and abdominal approach, whereas the acceptance of male sterilisation was dependent upon the separation of vasectomy and castration – complicated by changing understandings of masculinity. Both factors were resolved in the 1970s, witnessed in the widespread uptake of contraceptive sterilisation in this period: from a surgical perspective, in the case of tubal ligation this popularity was intrinsically linked to the introduction of laparoscopic technology. In contrast the popularity of vasectomy was facilitated by in depth research and discussion on the psychological effects of the procedure, with an emphasis on the difference between vasectomy and castration. For the most part, this surgical history directly influenced doctors' experience of sterilisation, rather than patients’, as patients were unlikely to be informed of the technical details of their procedure and were instead
motivated by a desire to avoid unwanted pregnancy. Often overlooked in the history of sterilisation is the neutrality of surgical technology – the same procedures can be equally applied in a voluntary or coercive context. For the most part, contraceptive sterilisation is overlooked in favour of analysis of eugenic or coercive sterilisation, and technology is a rare area in which these concepts can be considered side by side. The complex relationship between eugenics, contraception, and sterilisation will be analysed in detail in chapter two, bearing in mind this history of surgical technology, as the practices outlined here characterised doctors’ performance of sterilisation procedures in the first half of the twentieth century.

142 For further discussion of this phenomenon see chapter four, ‘The Contraceptive Popularity of Sterilisation, 1970-86’.
Chapter Two – Sterilisation in the Early Twentieth Century, 1926-1950

Introduction

Contraceptive sterilisation is a global phenomenon, yet it is the concept of selective human reproduction – otherwise known as eugenics – that has become intrinsically embedded in both popular and scholarly understandings of sterilisation. Within existing academic discussion of sterilisation, eugenic, and particularly coercive, embodiments of tubal ligation and vasectomy have attracted far more attention than contraceptive sterilisation and the history of the former has been thoroughly documented in multiple national contexts.\(^1\) In contrast, there is a dearth of recent literature on contraceptive sterilisation, in spite of its popularity in this capacity.\(^2\) The term eugenics was developed by Francis Galton – a cousin of Charles Darwin – in 1883 and provided a name for what was an amalgamation of Malthusian theories of population and nineteenth century understandings of heredity and modernity. However, through links with the Holocaust and genocide, eugenics theory has become almost synonymous with coercive sterilisation in recent


\(^2\) Even in histories of birth control, sterilisation is frequently considered in a coercive rather than a contraceptive capacity, for example; Linda Gordon, The Moral Property of Women: A History of Birth Control Politics in America (Urbana and Chicago: University of Illinois Press, 2002), pp. 342-6; Lara V. Marks, Sexual Chemistry: A History of the Contraceptive Pill (New Haven and London: Yale University Press, 2010), pp. 18-21. John A. Ross (EngenderHealth), Contraceptive Sterilization: Global Issues and Trends (New York: EngenderHealth, 2002); is one of the few texts published since the 1980s that addresses contraceptive sterilisation, however this is promotional literature, rather than a historical study. EngenderHealth was formed in 1937 as the Sterilization League of New Jersey: after multiple name changes throughout the 1940s-90s, including the Association for Voluntary Sterilization, the organisation became EngenderHealth in 2001 and has promoted sterilisation consistently throughout the twentieth century.
decades. This is largely responsible for the stigmatised and controversial status of sterilisation in the twenty-first century: despite being a popular contraceptive, sterilisation is foremost associated with coercion and people with disabilities. Following the coining of the term, the eugenics movement quickly took off, achieving a transnational popularity that peaked during the interwar years, but would continue to hold currency for several decades to come. Based on the basic perception that some people were of greater or lesser value to the nation, race, or even humanity, eugenics was bound to contextual understandings of population, nationalism, technology, and quality – ideas which were expressed through both positive and negative eugenics. Positive eugenics aimed to promote reproduction amongst hereditarily desirable groups, whilst negative eugenics sought to restrict the reproductive capabilities of those perceived as “unfit”, primarily through sterilisation or segregation of these individuals.

In the Australian context, Rob Watts has argued that the effect of the eugenics movement on social welfare has been long lasting and influential, and that there was far more support for positive rather than negative eugenics. Physical education, mental health, maternal health, career guidance, IQ tests, sex education, contraception, and kindergarten were all promoted within the eugenics movement, in addition to segregation and sterilisation of the so-called unfit. However, in the same way that eugenics has become embedded in perceptions of sterilisation, the reverse has also happened and often eugenics is equated solely with the coercive sterilisation of the “unfit”. The function of this chapter

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is to address the relationship between eugenics, contraception and sterilisation in Australia, as this is something that has been frequently misread in understandings of sterilisation in the first half of the twentieth century. There has been a broad misconception that the history of sterilisation in this context is predominantly one of eugenics, rather than contraception. Although discussion of sterilisation in this period was largely eugenic, actual practices of tubal ligation and vasectomy were primarily contraceptive: the doctors performing these procedures were doing so with contraceptive intent and saw a clear distinction between operating for contraceptive and eugenic purposes. This emphasis on documented discussion assumes that sterilisation practices were part of the public sphere and that they followed an official narrative. It unwittingly conceals the tangible yet undocumented history of tubal ligation and vasectomy practices that existed within the realm of the personal and private – experiences removed from the public eye, except to those who sought them out.

Unlike some states in the US, Canada, and Scandinavia – where eugenic sterilisation was a legislated, government sanctioned and public affair – in Australia this legislation never eventuated and in spite of public support for the idea, sterilisation remained a private matter. Stephen Garton has recently argued that in Australia, eugenics was simultaneously everywhere, nowhere, and somewhere: everywhere in the pervasiveness of eugenic ideas, nowhere in the lack of eugenic legislation enacted, and

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8 Vasectomy Patient Cards 1934-76, Boxes 63, 65, 66, Victor Hugo Wallace Collection, University of Melbourne Archives [hereafter VHWC].
somewhere in terms of the influence these ideas had on social welfare practices.\(^9\) Within existing secondary literature, sterilisation is frequently placed in the “nowhere” category of the Australian eugenics movement because efforts to legislate the practice were unsuccessful and sterilisation remained legally ambiguous.\(^10\) However this understanding is based on official, legal documentation from this period and unquestioningly accepts the authority of governmental regulation within tubal ligation and vasectomy practices. Instead, it was the medical profession who had the real regulatory power in this context and despite an absence of legislation, eugenically justified sterilisation took place in private practice throughout, and well beyond, the first half of the twentieth century, albeit to a far lesser extent than contraceptive sterilisation: it is the distinction between these practices that is important to note here, as this is what makes it possible to separate histories of eugenic and contraceptive sterilisation.\(^11\) Despite the fact that the global eugenics movement lost currency several decades ago, the notion that certain people should not have children has endured. In the same way that contraceptive sterilisation should not be confined to the second half of the twentieth century, the occurrence of eugenic sterilisation cannot and should not be confined to the first half of the twentieth century. The majority of doctors interviewed for this project unapologetically discussed cases of eugenic sterilisation that took place throughout their careers – all of which problematises current perceptions of the history of sterilisation in Australia.\(^12\)


\(^11\) Papers relating to sterilisation in Woman magazine and public lectures, Boxes 2.25 and 2.1, Norman Haire Collection, University of Sydney Rare Books Collection [hereafter NHC]; Vasectomy Patient Cards, Box 63 and 65.A, VHWC; Interview with Dr Stefania Siedlecky by Tiarne Barratt, 2 September 2013; Interview with Dr Bruce Errey by Tiarne Barratt, 15 January 2014; Interview with Dr Barbara Simcock by Tiarne Barratt, 24 July 2013; Interview with Dr Ian Stewart by Tiarne Barratt, 26 November 2013.

\(^12\) Diana Wyndham verbalises the thoughts of many, stating that ‘Legislative backing was a necessary prerequisite for the implementation of negative [sterilisation] eugenics policies.’ And that ‘Events of the
This chapter reconsiders the relationship between eugenics, contraception and sterilisation: eugenic sterilisation was not replaced by contraceptive sterilisation, but rather they coexisted throughout the twentieth century. These histories are at once inextricably connected and very much separate in this context, because although the same people were often involved in both, they viewed them as distinctive concepts. Over time a gradual shift occurred and discussion of sterilisation altered, so that by the second half of the twentieth century, the focus was predominantly contraceptive, rather than eugenic. Throughout this period however, doctors could sterilise whomever they chose – with patient consent – for whatever reason they chose and this chapter highlights the distinct difference between what was said and what was done in relation to practices of tubal ligation and vasectomy.

As outlined in chapter one, individual doctors played a central role in the history of sterilisation. They were the people with the surgical knowledge and subsequent authority to perform these procedures and they did so – in private practice, in operating theatres, behind closed doors, quietly and at their own discretion. Chapter two closely follows the careers of three Australian doctors, Victor Hugo Wallace, Norman Haire and Stefania Siedlecky, all of whom were performing vasectomies, tubal ligations, or both at some point during 1926 to 1950. Beginning in 1926, this chapter unfolds chronologically and focuses on racial hygiene associations, their discussion of legality and eugenic sterilisation, the Catholic Church’s opinion on sterilisation during this period, and the personal experiences of Wallace, Haire and Siedlecky as they relate to sterilisation, gender, medical authority and education. This collection of topics demonstrates the interconnected nature of eugenics, contraception and sterilisation, whilst also highlighting the clear distinction

1930s weakened support for sterilization, and after news of German practices in World War II contemplation of eugenics or sterilization became utterly repugnant.’ However the surgical practices of the aforementioned doctors contradict this statement; Diana Wyndham, ‘Striving for National Fitness: Eugenics in Australia 1910s to 1930s’, unpublished PhD thesis, supervisor Professor Roy McLeod, University of Sydney, 1996, pp. 305, 327.
between the history of eugenic sterilisation and the history contraceptive sterilisation in twentieth century Australia.

**Eugenics, Racial Hygiene Organisations, and Sterilisation**

The Racial Hygiene Association (RHA) of New South Wales (NSW) and the Eugenics Society of Victoria (ESV) were two of the largest and longest functioning racial hygiene associations in Australia. These groups are used here as a representative sample of the public discussion around eugenic sterilisation that took place in the 1920s, ‘30s and ‘40s in order to emphasise the difference between discussion and practice that is often absent in narratives of sterilisation. The history of these organisations is significant because it contributes an explanation as to why the history of sterilisation in Australia is widely perceived as one of eugenics rather than contraception: these groups founded the early birth control clinics in Sydney and Melbourne and advocated sex education and access to contraception, yet their discussion of sterilisation was confined to the context of the “unfit” and “feebleminded”. In contrast, contraceptive sterilisation was rarely discussed publicly and has left far less traces of its existence in this period, even where members of these organisations were concerned. This highlights the interconnected yet separate nature of eugenic and contraceptive sterilisation in the first half of the twentieth century, because

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13 These groups do not represent the only support for (or opposition to) eugenic sterilisation and segregation in this period and considerably more public discussion took place than what is outlined in this chapter. However the full extent of this discussion is not relevant here, for a full account see Wyndham, ‘Striving for National Fitness’, pp. 305-28.
14 These groups were not the only ones involved in the establishment of early birth control clinics, for example in 1931 Marion Piddington opened a sex education clinic in Sydney: for more on Piddington and the relationship between birth control and eugenics in 1930s Australia, see Ann Curthoys, ‘Eugenics, Feminism and Birth Control: The Case of Marion Piddington’, *Hecate* vol. 15, no. 1 (1989), pp. 73-89.
although the same people were often involved in eugenic discussion and contraceptive
practices, they saw a clear distinction between these concepts, which is demonstrated in
the careers of Wallace, Haire and Siedlecky – all of whom differentiated eugenic
sterilisation from contraceptive sterilisation.

The RHA was founded in 1926 by a group of predominantly middle-class feminist
women, with two primary goals: the provision of sex education – which remained a core
characteristic of the organisation – and the eradication of venereal disease – considered to
be a ‘scourge of humanity’, yet an achievable obstacle in the realisation of national
health.16 The RHA was an Australian equivalent to the British Social Hygiene Council –
also founded with the aim to combat venereal disease – and members viewed health as the
cornerstone of a successful nation, reflected in their attitudes towards immigration.17 They
called for more rigorous health checks and ‘Strict enforcement of Immigration Laws, not
only in relation to British born subjects, but also aliens; if found deficient within a certain
period, they should be either deported or sterilized.’18 As the twentieth century progressed,
the organisation became increasingly concerned with the provision of contraceptive
services and was rebranded in 1960: the RHA became the Family Planning Association
(FPA) of NSW – the early eugenic focus carefully ignored in light of the new emphasis on
birth control, women’s health, and reproductive rights.19 This transition from racial
hygiene to the provision of birth control was not necessarily the obvious route for the RHA
to take, and internationally, it was one of the few racial hygiene groups to establish birth

16 ‘Racial Hygiene Association Appeal’, 28 September 1927, Racial Hygiene Association of New South
Wales (RHA) 1928-9 Annual Report, Mitchell Library [hereafter RHA, ML]; Benjamin Fuller and L.E.
Goodisson, Australian Racial Hygiene Congress 1929: Report, September 15th, 16th, 17th & 18th (Sydney:
Wingello House, Angel Place, 1929), p. 1; Frank Bongiorno, The Sex Lives of Australians: A History
17 For a full account of racial hygiene, race and immigration in this period see Bashford, Imperial Hygiene,
pp. 154-5, 137-63.
19 Stefania Siedlecky and Diana Wyndham, Populate and Perish: Australian Women’s Fight for Birth
Control (Sydney: Allen and Unwin, 1990), pp. 113, 215; Wyndham, Eugenics in Australia, p. 3.
control clinics, to take a consistent interest in women’s access to contraception, or to
remain active in the twenty-first century.\textsuperscript{20} In addition to the promotion of sex education
and the prevention of venereal diseases, members of the RHA were concerned with raising
the profile of racial hygiene and eugenic understandings of health and fitness in a context
where they felt such matters had been neglected, to the detriment of society.\textsuperscript{21}

Although much agitation has taken place in past years on the part of various
public bodies, on the whole, Australia has not realised the gravity of the
problem of feeblemindedness in all its sinister aspects throughout the
community. The result of this apathy is that in some of the older settled parts
of Australia, mental defectives are breeding freely and bringing to those parts
of the community all the evils which are associated with mental degeneracy,
such as crime, pauperism, venereal disease, bad housing and poor sanitation.\textsuperscript{22}

They were strong advocates of pre-marital health examinations as a precautionary measure
to prevent people perceived as mentally defective from having children, and increasing
social awareness of these issues was at the centre of the RHA’s work. In addition to their
discussion of segregation and sterilisation of the unfit, they held public lectures, hosted
educational film screenings, provided sex education in schools, convened conferences,
transmitted weekly radio broadcasts and set up birth control clinics.

In the second half of the twentieth century, the RHA went on to become one of
Australia’s leading providers of contraceptive sterilisation services: in 1972 Family
Planning NSW established the first official vasectomy clinic in Australiand the
organisation successfully referred women for tubal ligation procedures from the mid-1960s

\textsuperscript{20} Emile Paquin, ‘Social Hygiene in New South Wales, Ontario and Quebec: A Comparative History of Two
Organisations’, unpublished thesis, Master of Philosophy, The University of Sydney, supervisor Professor
\textsuperscript{21} RHA, 1930 Annual Report, ML.
\textsuperscript{22} Dr Lorna Hodgkinson, ‘Mental Deficiency as a Problem of Racial Hygiene’, in Fuller and Goodisson,
\textit{Australian Racial Hygiene Congress 1929}, p. 35.
However the original members of the RHA possessed a starkly different view of sterilisation from those of later generations. When the RHA opened its first birth control clinic in Sydney in 1933, there was no question that sterilisation would not be one of the services offered: apart from a severe lack of funding and resources, sterilisation – which required surgical skill and sterile operating facilities, a far cry from the amenities available – was considered separate from their birth control initiatives. As the views and actions of the RHA were based on eugenic understandings of health and population, in the early years its members supported sterilisation only in the context of the so-called unfit or feebleminded:

These mental defectives are a great burden to Society, causing gloom, fear and inferiority complexes. Our Society takes a very definite stand on that point and openly advocates sterilisation of the unfit. In England in 30 years the increase in mental defectives has been from 150,000 to 300,000. In Australia it is somewhat difficult to estimate, but it is on the increase and if for no other reason we should advocate sterilisation of the unfit from the financial point of view – President of the RHA, 1932.

The views of the President of the RHA were supported by the organisation’s members, who believed that eugenic sterilisation would benefit those individuals directly involved, as well as broader Australian society:

As regards eugenic methods, if people are unhealthy, you can’t tell them they must not marry! You can’t tell them they must be continent! But you can sterilize them, or, by teaching them methods of birth control, restrict their family to one offspring, if for various reasons, a child is necessary. Sterilization is a method which would be good for the community and the same could be applied in cases of people suffering from nervous debility, and with epileptic histories. Three generations can be affected by a certain disease.

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23 Interview with Dr Barbara Simcock by Tiarne Barratt, 24 July 2013.
25 ‘Opening Address’, RHA 1932 Annual Report, ML.
and, in the interests of morality, breeding should be prohibited in those cases, for the germ of heredity will come out sooner in the offspring they may have – Dr Granville Waddy, 1929.26

These sentiments demonstrate the context in which members of the RHA understood sterilisation: for many, its contraceptive capacity was incomprehensible, which partially explains why contraceptive sterilisation increased in popularity only very gradually throughout the first half of the twentieth century – even its greatest proponents had some difficulty accepting sterilisation in this role and as Waddy’s statement reveals, birth control and sterilisation were considered separately. This distinction further demonstrates that academic consideration of sterilisation in this period requires further refinement, as it is often the case that discussion is implicitly eugenic, which erases the presence of surgical contraception in this environment.27

The RHA advocated the availability of legal voluntary sterilisation, but strictly in the relation to people who were ‘mentally defective’, suffered from a ‘grave physical disability’, or were ‘likely to transmit a mental disorder or defect’.28 They argued that any person with hereditary defects had the right to readily accessible voluntary sterilisation, hence they were displeased with the ambiguity that characterised the legal status of sterilisation. ‘[O]wing to there being no ruling in the New South Wales Laws, whether it [sterilisation] is legal or illegal, the position is very unsatisfactory.’ 29 This was a common attitude and the legality of voluntary sterilisation in Australia has never been officially clarified. Throughout this period, and indeed the second half of the twentieth century, there were people who insisted that sterilisation was unlawful – ‘The Australian law, like that in

29 RHA 1936 Annual Report, p. 3, ML.
England, is so indefinite that our Doctors are very chary of performing this operation, unless for serious health reasons,’ – and people who insisted that it was entirely legal.30 Although no doctor was ever prosecuted for performing a tubal ligation or vasectomy, uncertainty lingered for several decades and for this reason many members of the RHA favoured segregation of the unfit over sterilisation – a feeling that was echoed in Victoria.31 The legal situation was no more transparent in Victoria and comparable to the RHA, members of the ESV felt that clarification was necessary if people were to gain appropriate access to these services: they regarded the British Medical Association (BMA) as authoritative and wished to know ‘what would be the attitude of the Ethics Committee of the British Medical Association towards one of its members who performed an operation for sterilisation.’32 Unfortunately for the ESV, the BMA maintained that sterilisation was unlawful except in strictly therapeutic circumstances, akin to that of the conditional legality of therapeutic abortion, until 1960.33 Throughout the 1920s and ‘30s several mental deficiency bills were proposed in Victoria, the last in 1939. These bills recommended the segregation of people considered to be mentally deficient, with the aim to limit reproduction via institutionalisation – a scheme thought to cause less public outrage than large-scale sterilisation.34 The ESV attempted to capitalise on this in 1939 by raising issues of legality, yet there was not enough public demand to support eugenic sterilisation:

30 RHA 1937 Annual Report, p. 4, ML; Wykeham Terriss, ‘A Doctor Looks at Life – Law and Sterilisation’, Woman, 19 September 1949, Box 2.25 (1), NHC.
32 ESV 1939 Annual Meeting Notes, p. 35, Box 3, VHWC.
34 Jones, ‘The Master Potter and the Rejected Pots’, pp. 324-5, 328; This is only one example of proposed legislation relating to mental deficiency around Australia, similar events took place in various other states, a full account of which can be found in Wyndham, ‘Striving for National Fitness’, pp. 317-21.
In 1939, when the Mental Hygiene Bill was about to be introduced in the State Parliament our Society requested that it include provision to make sterilization legal when it was volunteered by persons suffering from mental deficiency and mental disorders due to hereditary causes. Our request was refused by the Chief Secretary, who stated that ‘the records of the Department of Mental Hygiene did not contain a single instance of any person having sought permission to undergo the treatment.’35

None of these parliamentary initiatives ever materialised in Victoria and Ross Jones has argued that this inactivity was likely due to the lack of funds available for extensive segregation schemes in the context of the Depression and the Second World War.36

The ESV was founded in October 1936, born out of a meeting convened by Lilian Goodison, the secretary of the RHA, in the hope that a similar organisation would be formed in Victoria. Those in attendance expressed interest in: ‘education and social welfare, particularly in sex education, the prevention and eradication of venereal disease, the formation of family planning clinics and the dissemination of knowledge concerning eugenics.37 It was agreed that one organisation could not encompass this wide array of topics and eugenics emerged – slightly begrudgingly for some – as the direction in which to steer the groups’ efforts, with an aim to:

…bring about a state of affairs where persons of superior natural endowments shall have a higher, or at least not lower, birth rate than persons of inferior endowments; and to ensure that persons with gross defects of mind or body, known to show a tendency to be inherited, should be discouraged or prevented from producing children.38

However this lack of unified intent became a source of contention in future meetings, most notably in relation to birth control clinics. In 1939 the ESV attempted to open a birth control clinic, which elicited mixed reactions from several key members of the society who suspected that there was not enough public demand for a strictly eugenic clinic: they had recently been informed by the RHA that the vast majority of patients attending its birth control clinic did so for socioeconomic reasons, and only seven per cent for eugenic reasons.\(^{39}\) Though the ESV did open a relatively successful clinic in 1941, wartime rubber restrictions made pessaries difficult to manufacture, which necessitated its closure in 1942: this reveals that in spite of Wallace’s strong involvement with the ESV clinic, it was not connected to his private vasectomy practice.\(^{40}\) This further demonstrates that despite the popularity of eugenic ideas in the first half the twentieth century, it was a public demand for contraception that propelled the increasing availability of sterilisation services.

The ESV produced two publications throughout their twenty-five years of operation: ‘Eugenics and the Future of the Australian Population’ and ‘Voluntary Sterilization for Human Betterment’.\(^{41}\) Concerned with both positive and negative eugenics, the ESV believed that Australia was in need of a larger population ‘of good quality’ in order to be sustainable and at times felt that negative eugenics had come to take ‘undue prominence in popular eugenic literature.’\(^{42}\) Members called for increased immigration to boost the Australian population and like the RHA, the desired whiteness of immigrants was implicit in their concern for quality as they sought ‘persons sound in body

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\(^{39}\) ESV 1940 Annual Meeting Notes, p. 55, Box 3, VHWC; Wyndham, *Eugenics in Australia*, p. 177.


and mind and reasonably free from hereditary traits.\textsuperscript{43} In conjunction with immigration, the ESV advocated legal voluntary sterilisation in eugenic circumstances, situations where its members felt that society had a duty to intervene and limit the reproductive capacity of those they believed would otherwise be institutionalised.\textsuperscript{44} Sterilisation was viewed favourably as it allowed ‘persons suffering from hereditary diseases to marry without the dread of producing defective children’ and it reduced ‘one of the principle sources of mental disorders.’\textsuperscript{45} Nevertheless, the ESV never facilitated actual practices of sterilisation and its official involvement never progressed beyond discussion with the Victorian State Parliament and the BMA: this highlights the importance of distinguishing between what was said in this context and what was simultaneously happening behind closed doors. As a result of the 1925 Royal Commission on Health, William Ernest Jones – Victorian inspector-general of the insane – was appointed to undertake an enquiry into mental deficiency in Australia in 1928 as it had become considered a problem of ‘supreme national importance’. Sterilisation of the unfit fell within the parameters of this enquiry and Jones predicted that eugenic embodiments of this practice would not materialise in Australia.\textsuperscript{46} However as this chapter demonstrates, sterilisation was a private affair, dictated by individuals and key members of the professional medical community.\textsuperscript{47} Both locally and internationally individual doctors governed tubal ligation and vasectomy.

\textsuperscript{43} Agar, ‘Eugenics and the Future of the Australian Population’, p. 16.
\textsuperscript{44} Agar, ‘Eugenics and the Future of the Australian Population’, p. 7; Featherstone, \textit{Let’s Talk About Sex}, p. 157.
\textsuperscript{45} Booth, ‘Voluntary Sterilization for Human Betterment’, p. 5.
\textsuperscript{46} ‘The writer considers that sterilization will never be resorted to…until the economic pressure, arising from the increasing burden of lunacy and mental deficiency, has become very much more acute than it is at the present time.’; W. Ernest Jones, ‘Report on Mental Deficiency in the Commonwealth of Australia, Department of Health’ (Canberra: H.J. Green, Government Printer, 1929), pp. 3, 17.
\textsuperscript{47} In \textit{Medicine and Madness} Stephen Garton discusses psychiatrists’ public promotion of legislation that called for the segregation of the unfit. In contrast, doctors’ discussion of sterilisation fell outside the realm of public discussion and governmental regulation; Stephen Garton, \textit{Medicine and Madness: A Social History of Insanity in New South Wales, 1880-1940} (Sydney: University of New South Wales Press, 1988), pp. 77-8.
practices, which were becoming increasingly prevalent, illustrated by the release of *Casti Connubii* in 1930.\(^{48}\)

**The Catholic Church and *Casti Connubii***

On 31 December 1930 Pope Pius XI made the first official Catholic comment on sterilisation of the twentieth century when he released the encyclical *Casti Connubii* (On Christian Marriage), outlining a total ban ‘either for the reasons of eugenics or for any other reason.’\(^{49}\) The records of the RHA and the ESV can give the impression that ambiguous legal requirements were a major impediment to the widespread availability of surgical sterilisation. However, greater opposition came in the form of social and moral disapproval, the most tangible representation of which was the Catholic Church. It is valuable to consider the origins of this opposition, particularly given that discussion covered both eugenic and contraceptive sterilisation, and that these opinions continued to inform members of the Church throughout the twentieth century – the significance of which will unfold in chapters three and four. Prior to the release of *Casti Connubii*, there had been some confusion amongst prominent members of the church regarding the morality of eugenic embodiments of sterilisation.\(^{50}\) Pope Pius XI addressed this by condemning sterilisation under any circumstances, bar therapeutic, yet in the fashion of broader histories of sterilisation, academic discussion has focussed on coercive expressions of this practice when considering *Casti Connubii*.\(^{51}\)

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\(^{48}\) Booth, ‘Voluntary Sterilization for Human Betterment’, p. 11.

\(^{49}\) *Casti Connubii*, encyclical of Pope Pius XI on Christian Marriage, 1930, p. 70.

\(^{50}\) Hansen and King, *Sterilized by the State*, p. 137.

Casti Connubii was intended to address the functioning and conditions of Christian marriage in the modern world – sterilisation was just one segment of this encyclical. In the early decades of the twentieth century, there had been papal concern that the sacred institution of Christian marriage was becoming endangered by the changing social context of the time: war, industrialisation, shifting gender roles and new ways of understanding the world were thought to be influencing religious outlooks on life. There was worry that the laity were in danger of forgetting the importance of chaste wedlock in light of the day’s ‘pernicious errors and depraved morals’, taking form in increasingly liberal attitudes towards sex, contraception and population. Pius XI sought to reaffirm the dominance of natural law within marriage, by banning extramarital sex, divorce, contraception, abortion and sterilisation: civil law may have permitted these ‘social evils’, but Christian marriage would forever remain a divine institution immune to human interference – or so it was intended. The perceived need for this encyclical indicates the reality of changing attitudes within the Catholic community: this threat of disobedience triggered a firm reminder from Rome wherein the authority of the laity – or rather the lack of it – within the Church was made clear. However the long-term inefficiency of this approach became apparent in the international response to Humanae Vitae in 1968, which will be discussed in further detail in chapter three.

The doctrinal reasoning as to why sterilisation was and is not permissible within the Catholic Church stems from scripture and the idea that tubal ligation and vasectomy constitute bodily maim: ‘God created mankind in his own image, in the image of God he

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52 Leon, An Image of God, p. 94.
53 Casti Connubii, pp. 3-4.
54 Casti Connubii, p. 34.
55 ‘Catholic Mother of Six: I will go on taking the Pill’, Daily Mirror, 30 July 1968; this article is an example of the Australian public’s rejection of Humanae Vitae.
created them; male and female he created them…”56 In other words, humans are created by God, in the image of God, therefore human life is sacred and people do not have the authority to maim their bodies or interfere with bodily functions in any way.57 Sterilisation was, and still is, considered a mutilation because it interrupts natural reproductive functioning – an abomination to those who viewed humans as a creation of God, in the image of God. This equation of sterilisation with mutilation and maim was further exacerbated by the enduring association with castration that characterised vasectomy procedures. In the context of Casti Connubii, reproductive control was not considered a human right, people were not thought to have the authority to prevent conception through surgical interference:

…individuals have no other power over the members of their bodies than that which pertains to their natural ends; and they are not free to destroy or mutilate their members, or in any other way render themselves unfit for their natural functions, except when no other provision can be made for the good of the whole body.58

Sterilisation was seen to obstruct the natural functioning of reproductive organs, placing it in the category of mutilation, the only exception, as seen in this extract of Casti Connubii, was when the entire body was threatened by a particular organ, for example in the case of a prolapsed uterus or diseased fallopian tube. Papal authority argued that any condition requiring sterilisation – most commonly danger associated with further pregnancy – could be solved by abstinence rather than contraception: the body would only be threatened if the individual actually engaged in sexual activity, therefore it was interpreted that there was nothing inherently wrong with the reproductive organs, and their function could not be

56 Genesis 1:27.
58 Casti Connubii, p. 71.
lawfully diminished.\textsuperscript{59} For this reason hysterectomy was popular amongst Catholic women who could not reconcile tubal ligation with their consciences, or more likely their priests, who in many cases played an active role in the prohibition of sterilisation in the first half of the twentieth century.\textsuperscript{60}

Reverend M.F. Lane, a regular contributor to \textit{The Australasian Catholic Record} (ACR), was a fierce supporter of the sentiments expressed in \emph{Casti Connubii} and publicly articulated this throughout the 1930s in response to readers’ questions regarding the morality of sterilisation.\textsuperscript{61} He believed the encyclical to be one of ‘the greatest official pronouncements of the Holy See’ and felt that ‘for Catholics there can be no further doubt as to the unlawfulness of eugenic sterilization’.\textsuperscript{62} This opposition to eugenic sterilisation was unsurprising, considering that he felt that ‘The eugenicists lose sight of human dignity and the natural right of man, treating him in the same manner as domestic animals, which are selected and bred…done in the name of civilisation, while it reeks of barbarity and materialism.’\textsuperscript{63} However, it has been noted that \emph{Casti Connubii} did not reject positive eugenic ideas: the Church was in support of improving social conditions and remained involved in discussions of population and reproduction – it simply rejected negative eugenics in the form of contraception, sterilisation and abortion.\textsuperscript{64} Regardless of the context, representatives of the Church considered tubal ligation and vasectomy ‘grave mutilations’ that deprived ‘a person of [their] natural right of generating offspring’, a


\textsuperscript{60} Siedlecky and Wyndham, \textit{Populate and Perish}, p. 47.

\textsuperscript{61} The discussion examined here is based on opinions volunteered and published in \textit{The Australasian Catholic Record} throughout 1926-50. It serves as an example and does not encompass the plethora of attitudes that existed amongst the demographically diverse Australian Catholic community, attitudes that could be influenced depending on the state, or even congregation.


\textsuperscript{63} Rev M.F. Lane, ‘Moral Theology’, \textit{The Australasian Catholic Record} vol. 8, no. 2 (1931), p. 142.

\textsuperscript{64} Lepicard, ‘Eugenics and Roman Catholicism An Encyclical Letter in Context’, p. 533.
position that did not alter as negative eugenics diminished and contraceptive sterilisation flourished throughout the twentieth century.65

As will be established in chapters three and four, there was significant discord within the lay Catholic community regarding the Church’s teaching on birth control in the second half of the twentieth century – signs of which were already emerging in members of the Australian laity in 1940 – demonstrated in the following question submitted to the ACR, querying the Pope’s condemnation of contraceptive sterilisation.

What about the lawfulness of sterilization in the case of those who desire to render themselves incapable of procreating offspring? I have seen this defended. Man and woman, it was said, are the masters of their own bodies, and if they can renounce their right to marry, or to procreate children in the married state, why may they not, of their own free will deprive themselves of the very faculty of generating? Such a procedure, it was even maintained, could be justified from the Bible (Matt. XIX, 12). Priests and religious voluntarily renounce the right to marry and why cannot others with equal right submit to sterilization?66

The reader had signed their question ‘anti-eugenics’, indicating that they clearly perceived the morality of eugenic and contraceptive sterilisation differently: just as supporters of eugenics could be in favour of contraceptive sterilisation in the absence of hereditary conditions, so could opponents of eugenics. This distinction reveals that it was common for both people and groups to define eugenic and contraceptive sterilisation differently in the first half of the twentieth century and supports the argument that these practices coexisted. Although the catalyst for this comment on sterilisation in Casti Connubii was international discussion of eugenic sterilisation, these judgments were equally applied to

65 Lane, ‘The Morality of Sterilization’, p. 50.
contraceptive embodiments. By 1950 discussion of sterilisation published in the ACR no longer contained references to eugenics, rather the focus had become contraception – though the same principles were used to condemn these practices regardless.\(^{67}\) While there was some opposition to the Catholic ban on contraception, the strength of this institutional disapproval should not be underestimated, seen in the career of Dr Victor Hugo Wallace and his attempts to hide the contraceptive nature of his work from the Victorian Catholic community in the 1930s.\(^{68}\)

**Victor Hugo Wallace (1926-49)**

The career of Melbourne doctor, Victor Hugo Wallace (1893-1977) – eugenicist, birth controller and vasectomist – embodies the complex and often contradictory relationship between eugenics, contraception and sterilisation in the first half of the twentieth century. From 1936 to 1961 Wallace was the secretary of the ESV, active in their birth control clinics, public meetings and discussion of sterilisation of the unfit.\(^{69}\) He also provided women with contraception both in public clinics and in his own private practice and was vocal in his public support for birth control, advocating its necessity while at the same time maintaining that Australia desperately needed a larger population – a position that he outlined in his 1946 volume, *Women and Children First*.\(^{70}\) Yet in addition to his public career as a eugenicist and birth controller, Wallace consistently maintained a private vasectomy practice from 1934 to 1976, where, removed from the public eye, he performed contraceptive sterilisations at a modest profit.\(^{71}\) In the same way that Wallace

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\(^{68}\) Wallace, ‘The Development of Family Planning in Australia’, pp. 4-5, Box 35, VHWC; ‘Patient History Cards’, Box 63, VHWC.


\(^{71}\) Vasectomy Patient Cards, Boxes 63 and 65, VHWC; Between 1934-49 Wallace’s vasectomy rates increased from £10 to £21 – by 1970 the cost was $100, approximately fifty per cent more than Bruce Errey
differentiated between providing women with birth control for contraceptive and eugenic purposes, he applied this view to sterilisation and operated ‘mostly for socio-economic reasons. Married people are entitled to choose surgical sterilisation when they have good reasons for doing so.’\textsuperscript{72} This problematises current understandings of the interconnectedness of eugenic and contraceptive sterilisation in this period – as well of Wallace himself – an idea that will be analysed in this chapter using archival records of Wallace’s vasectomy practice from 1934-49.

Wallace is a familiar figure in Australian histories of sex, sexuality and birth control: his role in the provision of female contraception and sexual counselling is frequently acknowledged – although often only referenced in passing.\textsuperscript{73} When Wallace’s career has taken a more prominent focus in these histories, it has been in relation to discussions of female sexuality and the large birth control survey that he conducted in the 1940s.\textsuperscript{74} Throughout 1943-44, he surveyed 530 of his private patients as to why they chose to employ contraceptive measures and over 150 of these responses have survived: now housed in the University of Melbourne Archives, these letters provide unique insight into women’s attitudes towards sex, sexuality and reproduction in this context.\textsuperscript{75} Yet alongside these female contraceptive cases, exists over 200 records of individual vasectomy patients – often with letters explaining the men’s reasons for desiring the operation – which have been unintentionally omitted from existing accounts of Wallace’s career. These records

\textsuperscript{72} Wallace, ‘Vasectomy’, p. 212; Wallace, Women and Children First, p. 66.
\textsuperscript{73} Featherstone, Let’s Talk About Sex, pp. 229-43; Bongiorno, The Sex Lives of Australians, pp. 193, 197, 201-3; Siedlecky and Wyndham, Populate and Perish, pp. 165-6.
\textsuperscript{75} Survey responses located in Box 45, VHWC.
illuminate practices of contraceptive sterilisation in Australia: they reveal that its long-standing popularity was not confined to the second half of the twentieth century, and that there is a history of sterilisation that can, and should, be separated from the eugenics movement in the first half of the century.

The Wallace archive is extremely popular, primarily for the material it provides about the ESV and the history of the eugenics movement in Victoria: this focus is somewhat curious because this archive has equal, if not more, material on the history of birth control.\(^76\) Victoria is a state with a long and diverse history of family planning initiatives – it was the first state where a State Government became involved in the provision of contraceptive services – and Wallace is a large part of that history. In addition to his private work with female contraceptives and vasectomy, in 1934 he opened the state’s first birth control clinic, the Women’s Welfare Clinic (WWC), all of which is reflected in an extensive archival collection.\(^77\) This preoccupation with eugenics in a period referred to as a eugenic half-century, can overshadow Wallace’s contribution to other areas of society. In a rare example of scholarly consideration of Wallace’s identity as a vasectomist, Diana Wyndham has noted that he was in fact performing vasectomies in the 1930s. However she described the setting as a ‘eugenicists’ clinic’, perpetuating the belief that sterilisation cannot be disengaged from understandings of eugenics in this setting.\(^78\) Alison Bashford, in *Imperial Hygiene* has recognised the prevalence of voluntary sterilisation in private practice throughout the first half of the twentieth century and the

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\(^77\) Siedlecky and Wyndham, *Populate and Perish*, p. 187; Wallace, ‘The Development of Family Planning in Australia’, pp. 5-6, 14, Box 35, VHWC; In addition to providing contraception to his own private patients, Wallace wanted to extend this work, first to a public clinic and eventually to a medical centre that would provide not only birth control, but also counselling and treatment for infertility and sex problems. In an attempt to avoid criticism from both the Catholic Church and the medical profession, the WWC operated in conjunction with the Melbourne District Nursing Society, with as little publicity as possible. The clinic stayed in operation until 1940, after which Wallace teamed up with the ESV in future public endeavours.

need for further research on this subject: while at the same time upholding the dominance of eugenic ideas in this context by maintaining that it was ‘another kind of *cordons saunittaires* with the future’.\(^79\) Though Wallace supported a population of high quality, it was not the opportunity to perform ‘a eugenically satisfying cut’ that motivated his vasectomy career.\(^80\)

Wallace had a strong personal investment in the provision of birth control: he was genuinely concerned about access to contraception and this permeated his career. He thought that ‘Parenthood should be voluntary. Man controls nature in a thousand other ways, to his material and intellectual advantage. Why should he not control the size of his family in accordance with medical, eugenic and economic considerations?’\(^81\) In line with these beliefs, he felt that contraception contributed positively to society in the form of:

> The emancipation of women; the welfare of children already born; the living standard enjoyed by the family as a whole; national population growth; the effect on the quality of the general population (i.e. eugenic or dysgenic); population pressure, peace of the world and the happiness of mankind.\(^82\)

As was characteristic of the era, there was considerable overlap in his views relating to health, population, eugenics and birth control. In spite of Wallace’s advocacy of contraception and concern regarding global overpopulation, in 1946 he argued that Australia needed a significantly larger population – although in line with his eugenic ideals, his concern was for quality as well as quantity.\(^83\) In this immediate post-war context a population that could sustain national defence was a high priority, though Wallace was equally concerned with fostering intellectual and creative culture, which he believed would

\(^80\) Bashford, *Imperial Hygiene*, p. 181.
\(^81\) V.H. Wallace, ‘Should Parenthood be Voluntary?’, *The Rationalist* vol. 16, no. 5 (1939), p. 66.
\(^82\) Wallace, ‘The Development of Family Planning in Australia’, pp. 1-2, Box 35, VHWC.
benefit from a greater population.\textsuperscript{84} Wallace had a diverse range of interests, of which contraception was possibly the most enduring, as he spent the final years of his life writing a history of family planning in Australia: drawing on a combination of personal experience and new research, Wallace outlined his contribution to the field. After graduating from a medical degree at the University of Sydney in 1918, he set out on a tour of Europe in 1921 where he was considerably influenced by the ‘valuable pioneering’ work of Marie Stopes and the birth control clinic she ran in London. Returning to Australia in 1926, Wallace located himself in Melbourne and entered private practice in 1928. The ‘Great Depression was looming’ and in this period of financial hardship, Wallace provided patients with birth control and contraceptive advice. Less than six years later, in 1934 he had progressed to performing vasectomies – the beginning of a career that would span the next four decades, with people travelling up to 2000kms across Australia, and even as far as New Zealand in search of his vasectomy services.\textsuperscript{85}

From 1934 to 1976, Wallace performed approximately 350 vasectomies in his private practice, the majority of which were done ‘purely for contraceptive purposes’, ‘mostly for socio-economic reasons’.\textsuperscript{86} Of these patient records, 230 have survived, providing quantitative data for around two thirds of the operations that he performed. This makes Wallace one of the earliest documented providers of contraceptive sterilisation in Australia and his vasectomy patient cards are a unique resource on surgical contraception in the first half of the twentieth century. From 1934-49, Wallace recorded thirty-eight


\textsuperscript{85} Wallace, ‘The Development of Family Planning in Australia’, pp. 4-5, Box 35, VHWC; Patient History Cards, Box 63, VHWC; Patient cards and letters, Box 45, ‘Miscellaneous’, VHWC; Box 63, ‘Patient History Cards’ and Box 65.A ‘Patient History Cards Concerning Vasectomy (1940-60)’, VHWC.

\textsuperscript{86} Wallace to Haynes, 26 May 1967, Box 5, VHWC; Wallace, ‘Vasectomy’, p. 212; Note that in ‘Vasectomy’ Wallace states that he began performing vasectomies in 1936, however his patient records clearly show that his first operation took place in 1934. See Figure 2.1.
vasectomy patients: of these men, one sought the “rejuvenating” properties of vasectomy, three listed eugenic and hereditary concerns as their motivation for sterilisation, and the remaining thirty-four men’s procedures were “purely contraceptive”.87 Although isolated examples of rejuvenation and heredity did occur on occasion, overall it was socio-economic motivators that drove the demand for Wallace’s vasectomy services: somewhat controversially, the vast majority of his patients simply did not want any more children. Yet more controversially, he sterilised men on these grounds alone. He sterilised single men, he sterilised men with no children, he sterilised men in their early twenties – if they were prepared to sign a legally binding letter of consent acknowledging the permanent nature of the procedure, then he was prepared to operate.88 These practices were controversial in the 1960s and ‘70s, let alone in the early twentieth century, but as a doctor with surgical skill and a desire to operate, Wallace’s vasectomy practice was entirely self-regulated and he could accept or deny patients at his own discretion.

Unlike his provision of female contraceptive services, vasectomy remained an unpublicised aspect of Wallace’s work until the 1970s. In Women and Children First he acknowledged the availability of sterilisation: ‘Of course the surgeon could readily sterilise either husband or wife in such cases by the simple ligation and division of certain tubes or ducts…’, yet remained silent regarding his personal experience.89 As a result of this silence, his patient records serve as the primary source of information on this aspect of his career and it is unclear as to exactly how Wallace became involved in contraceptive sterilisation. On 23 June 1934, a young man from Springvale, Victoria was referred to Wallace’s rooms, where his patient card recorded that: ‘He has two children. He and his wife have tried a great variety of contraceptive methods, but each has failed. They now

87 Vasectomy Patient Cards, Boxes 63 and 65, VHWC.
88 Vasectomy Patient Cards, Box 65.A, VHWC.
89 Wallace, Women and Children First, p. 42.
desire complete freedom from further anxiety. Vasectomy performed under local anaesthesia: sterilised.\textsuperscript{90} This patient marked the beginning of Wallace’s career in contraceptive vasectomy. Tentative in these early days, Wallace took the time to record the details of the operation, making careful notes about the surgical technique he employed, the anaesthetic used, the recovery process, and the intriguing notion that the patient reported a noticeable increase in post-operative sexual stamina – perhaps a product of the believed “rejuvenating” capabilities of vasectomy circulating amongst members of the medical profession in the early twentieth century.\textsuperscript{91} This man serves as a reasonable representation of Wallace’s vasectomy clientele: the average patient during this period was thirty-eight years old, married, with 2.5 children representing a completed family. Yet it is the details of these case studies that provide real insight into the demand for surgical contraception in the first half of the twentieth century.

\textsuperscript{90} Vasectomy patient card, Box 63, VHWC. This is the earliest dated vasectomy patient card in the Wallace archives. Although these archives do not represent a complete collection of vasectomy patients, it is reasonable to assume that this card represents the first operation: in later years Wallace remembered his first operation to have taken place in 1936, therefore it is unlikely that he was performing vasectomies prior to 1934.

\textsuperscript{91} See Figure 2.1; Norman Haire, \textit{Rejuvenation: The Work of Steinach, Voronoff, and Others} (London: Allen and Unwin, 1924); Wyndham, \textit{Norman Haire and the Study of Sex}, pp. 87-90.
Figure 2.1: 1934 anonymous* vasectomy patient card, Box 63, Victor Hugo Wallace Collection, University of Melbourne Archives.  
*In line with this collections privacy policy, all of the patient’s identifying details have been omitted.

Within the broad heading of contraceptive vasectomy, there were many personalised reasons as to why men wished to become permanently sterile. Although it is possible to develop a portrait of the “average” vasectomy patient who sought out Wallace’s services, each record is unique and whether it be in regard to age, marital status or number of children, there were nuanced differences in patients’ individual histories – demonstrated in the following six case studies from the 1940s. 92 Kate Fisher has argued that until the middle of the twentieth century, both men and women viewed contraception as a ‘man’s duty’, settled firmly in the domain of the public, male sphere. 93 Though she applied this argument to reversible birth control, it is also applicable in the context of contraceptive vasectomy. For example, in 1942 a thirty-seven year old man, married with three children and employed as a butcher, required Wallace’s vasectomy services because

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92 See Figure 2.2.  
his wife had recently miscarried and this course of action was designed to spare her from future pain in this regard.\textsuperscript{94} Similarly, in 1944 Wallace performed a vasectomy on an R.A.A.F pilot, aged forty years, who was married with no children: the man’s wife was in ill health, and stated that they simply ‘don’t want children.’\textsuperscript{95} In this setting, a man’s use of birth control was often used as a measure of his consideration for his wife and commitment to his role as provider and protector, as vasectomy could be seen as the ultimate expression of that role.\textsuperscript{96}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|}
\hline
Year of vas. & Age at time of vas. & No. of children & Marital status & Occupation & Reference (VHWC) \\
\hline
1942 & 37 & 3 & Married & Butcher & Box 63 \\
1943 & 40 & 3 & Married & Unknown & Box 63 \\
1944 & 40 & 0 & Married & R.A.A.F & Box 63 \\
1944 & 42 & 0 & Single & Soldier & Box 63 \\
1948 & 30 & 2 & Married & Unknown & Box 65.A \\
1949 & 30 & 6 & Married & Rubber worker & Box 65.A \\
\hline
\end{tabular}
\caption{Six case studies of contraceptive vasectomy from the patient records held in the Victor Hugo Wallace Collection at the University of Melbourne.}
\end{table}

The provider role encompassed the health, happiness and economic situation of the family: ensuring the physical and mental health of one’s partner and offspring, and providing for existing children by giving them the best opportunities possible. This idea of “breadwinner masculinity” is generally discussed as characteristic of the 1950s – an idea that will be analysed in further detail in chapter three – however this role was clearly emerging in the 1940s, seen in the following examples of contraceptive vasectomy.\textsuperscript{97}

\textsuperscript{94} Box 63, ‘Patient History Cards’, VHWC.
\textsuperscript{95} Box 63, ‘Patient History Cards’, VHWC.
\textsuperscript{96} Fisher, \textit{Birth Control, Sex and Marriage in Britain}, p. 194.
1943, a married man, aged forty-two years and the father of three adult children, sought out permanent contraception after using condoms for the majority of his married life:

When you get up in years you can’t be bothered with young children. My father was 53 yrs old when I was born. He wasn’t unkind, but he never had any time for me. I think parents should mix with and enjoy their children’s company. We want to get about now without the children, and enjoy a bit of life before we get too old. Finance, housing, health, and the absence of domestic help have nothing to do with it. In our case it would be too big a gap [between pregnancies].

This statement is revealing because it demonstrates that Wallace would sterilise men who openly admitted that their health and financial situation could afford another child. It also shows that this man was acting in line with contemporary understandings of provider masculinity: he cared about his relationship with his wife and children and wanted to safeguard their happiness by undergoing a vasectomy. The following letter from 1948 comes from a married man, aged thirty years and the father of two young children – he sought a vasectomy for the following reasons:

In reference to the proposed vasectomy to be performed on me, I wish to state that both my wife and I fully realise the irrevocability of this operation. The reasons for our decision, which is the result of discussions extending over the two year period since the birth of our second child are briefly these. We consider that our present and likely future financial position would not allow the discharge of our parental responsibilities in the manner we believe our present two children require and deserve, should we have any more. Since I do not want any more children during my lifetime, vasectomy was decided upon as preferable to the equivalent operation on my wife because, not only simpler and less expensive, but, in the event of my demise, my wife would still be capable of having children should she re-marry. Her desire to do so however would be in the face of the extreme discomfort of former pregnancies and the

98 Box 63, ‘Patient History Cards’, VHWC.
relatively difficult births she has experienced; these factors have also contributed to our present decision.99

This example demonstrates qualities of an attempt to fulfil the provider identity in relation to economic considerations, a desire to provide for existing children and to spare his wife from the comparatively difficult operation of tubal ligation that would signal the definitive end of her reproductive potential. Although it must be acknowledged that these men were writing for a specific audience – one with the power to deny their request – nevertheless, these letters provide unique insight into experiences of surgical contraception in this period, revealing a real demand for these services that was entirely removed from contemporary considerations of eugenics, heredity, national health and population.

Wallace’s work in contraceptive sterilisation was progressive and ahead of its time because he did not actually require the kind of detailed explanation exhibited in the above letters, if the patient did not wish to provide it. The following two case studies are examples of men who chose not to provide any further clarification, apart from a desire to no longer have the capacity to father children. In 1949 a man of thirty years of age, married with six children, informed Wallace that he and his wife ‘did not wish to have anymore.’100 Although few doctors in support of contraception would have argued against a married man who had fathered six children using birth control, this was not why Wallace operated – he operated because the patient requested it and his number of children was likely irrelevant. In 1944, a soldier who had never been married and upon being discharged from the army at forty-two years of age, simply had no desire for children, similarly sought out a vasectomy, and Wallace complied.101 The different circumstances of these case studies are not reflected in their outcome, as Wallace refrained from passing personal

99 Box 65.A, ‘Patient History Cards Concerning Vasectomy’, VHWC.
100 Box 65.A, ‘Patient History Cards Concerning Vasectomy’, VHWC.
101 Box 63, ‘Patient History Cards’, VHWC.
judgement and performed the procedure on both men. This signifies his commitment to contraceptive sterilisation: although he did occasionally operate under eugenic circumstances, heredity was not the factor that decided whether or not he would grant a patient voluntary sterility – an attitude that was vastly different from his Sydney contemporary, Norman Haire, who made his patients work far harder to prove that they deserved permanent contraception. Somewhat ironically, it was Haire who was the controversial figure of the time, because although Haire was contentious in his public expression, Wallace’s private practice demonstrates that his actions were the more radical of the two.102

Norman Haire (1922-50)

Norman Haire (1892-1952) was an Australian surgeon and sexologist practicing throughout the first half of the twentieth century and he has left one of the most important sources of documentation regarding medical attitudes towards contraceptive sterilisation in this period – publications and personal papers bequeathed to the University of Sydney upon his death in 1952. Haire, despite having a strong commitment to birth control, was not an avid supporter of sterilisation in this context. Instead he was of the opinion that ‘No surgeon of repute would perform it, for instance, in healthy young men or women who might ask for it simply because they wanted to be free to indulge in sexual intercourse without fear of pregnancy resulting.’103 Haire used eugenics to formulate a scientific basis for understanding sexual morality and in line with this, primarily recommended sterilisation for members of society who were perceived to be physically or mentally

102 Wallace was the secretary of the ESV for the duration of its existence, while in contrast, Haire was denied membership to the RHA due to his controversial public status; Wyndham, Eugenics in Australia, pp. 91, 295. 103 Norman Haire, ‘Birth Control’, in Norman Haire eds., Some More Medical Views on Birth Control (London: Cecil Palmer, 1928), p. 48.
unfit. In 1922 he had sterilised four men and four women and publicly argued that ‘sterilization of the unfit is an essential element of any comprehensive scheme which aims at ameliorating the present unhappy condition of the vast bulk of humanity.’ It is clear from these two statements that Haire made a considerable distinction between contraceptive and eugenic sterilisation and the intent behind the procedure was fundamental to his perception of its appropriateness. This further supports the argument that histories of eugenic and contraceptive sterilisation existed independent of one another in the first half of the twentieth century – a distinction that is absent in existing discussion of Haire’s views on tubal ligation and vasectomy.

After graduating from the University of Sydney in 1915, Haire travelled to Britain in 1919 and did not return to reside in Sydney again until 1940, where he remained until 1946 before once again returning to Britain. During this long period of absence, Haire pursued his interest in gynaecology, birth control and sexology – achieving fame through his work on the rejuvenating capabilities of vasectomy. In 1920 Haire met Havelock Ellis, a man who he described as the ‘Darwin of Sex’ and who would later become his mentor. It was through this connection that he came into contact with other well-known figures of the time including Margaret Sanger, Magnus Hirschfeld and Edward Carpenter:

104 Bongiorno, Sex Lives of Australians, pp. 167-9; Wykeham Terriss, ‘A Doctor Looks at Life – Sterilisation Safeguard’, Woman, 1 March 1949, Box 2.25 (1), NHC.
106 Diana Wyndham has discussed Haire’s involvement in male and female sterilisation practices, but apart from discussing “rejuvenating” vasectomy separately, she makes no distinction between contraceptive and eugenic sterilisation: in discussions of contraception in the first half of the twentieth century, all consideration of sterilisation is implicitly eugenic and the difference between these practices remains overlooked; Wyndham, Norman Haire and the Study of Sex, pp. 241-4, 376-7; Siedlecky and Wyndham, Populate and Perish, pp.46-50.
108 Despite this absence, it is valuable to examine Haire’s career in London in addition to his practice in Sydney in the 1940s, as Australians frequently looked to England in terms of ideas, practices, and material relating to eugenics and birth control; Wyndham, Eugenics in Australia, p. 335; Wyndham, Norman Haire and the Study of Sex, pp. 104-8.
Haire soon became one of England’s most prominent sexologists.\(^\text{109}\) Akin to Wallace, Haire had a considerable personal interest and investment in the provision of birth control, often invoking his experience as an eleventh child and the strain that this put on his mother to demonstrate the need for contraception.\(^\text{110}\) Haire began his contraceptive career in London as a notoriously expensive Harley Street practitioner: additionally, he spent time running birth control clinics, was a member of a number of groups such as the Eugenics Education Society and the World League for Sexual Reform, both attended and organised many related conferences, and produced several publications relating to sex education – he even had his own brand of diaphragm in the 1920s.\(^\text{111}\) Amongst these activities, Haire also performed both male and female sterilisations in his private practice: as a sexologist with surgical experience he was in a position to act as an authority on the matter and more often than not, his interest in eugenics determined who could access these procedures. Although Haire believed that he held ‘very liberal views on the subject’ of sterilisation – which was accurate to an extent, as many doctors would not even consider performing these operations – he applied an authoritarian approach to patients’ requests for permanent contraception, demonstrated in the following examples.\(^\text{112}\)

In the early twentieth century individual doctors acted as the unofficial regulating body for sterilisation: decisions were based on rules internally created and upheld by the medical profession, and these ideas permeated sterilisation practices well into the latter half of the twentieth century.\(^\text{113}\) Although practitioners were able to use legal ambiguity as

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\(^{109}\) Wyndham, *Norman Haire and the Study of Sex*, chapter four ‘Haire the Phoenix’.


\(^{112}\) Journal of Sex Education, J.S.E. February 1952 Questions and Answers – Copy, in *Journal of Sex Education (Articles)*, Box 3.13, NHC.

\(^{113}\) This argument is based on the observation of the careers of several Australian doctors involved in the provision of contraceptive sterilisation, namely Haire, Wallace, Siedlecky, Errey, Simcock, and Stewart;
an excuse to reject patients’ requests for sterilisation, in reality issues of legality were largely irrelevant as doctors had the power to decide what surgery was and was not appropriate.  

A study of Haire’s career reveals that he frequently invoked heredity as a medical justification for vasectomy and tubal ligation, and in his opinion, people wishing to ‘avoid parenthood as a matter of personal convenience’ were unacceptable ‘applicant[s] for sterilisation’. He believed that sterilisation ‘in order to avoid a little trouble, or to allow of living in greater luxury’ was unjustifiable, and although he acknowledged that some doctors would operate under these circumstances, he was not involved in this practice. For example, in Woman magazine, Haire described a professional couple who wished to focus on their careers rather than reproduce and therefore sought permanent contraception via vasectomy:

When such people seek my advice or help, I spend a good deal of time and trouble making them understand the full implications of what they propose to do, and suggest that they should think it over for six months before coming to a final decision. If, after due consideration, they still persist in their intention, I tell them that, in my opinion, every adult person should have the right to decide in such matters for himself or herself, but that I think their decision an unwise one and I do not feel inclined to be a party to carrying it out. If they can find some other surgeon to do it for them, that is their affair, but I am not prepared to perform an operation which they may regret at a later date. In such a case, I advise them to use [reversible] contraceptives instead, so that, if they change their minds later on, they will still be able to have children.  

Siedlecky and Wyndham, Populate and Perish, p. 47; Articles in Woman magazine, Box 2.25 (1) and (2), NHC; Interview with Stefania Siedlecky, 2 September 2013; Interview with Bruce Errey, 15 January 2014; Interview with Barbara Simcock, 24 July 2013; Interview with Ian Stewart, 26 November 2013.  


Wykeham Terriss, ‘A Doctor Looks at Life – Don’t Decide Lightly’, Woman, 30 April 1945, Box 2.25 (2), NHC; Terriss, ‘Law and Sterilisation’, 2.25 (1), NHC.  

Norman Haire, ‘Sex Education – Sex and the Individual’ lecture no. 9, 13 November 1945, Adyar Hall, Box 2.1, NHC; Terriss, ‘Don’t Decide Lightly’, Box 2.25 (2), NHC.  

Terriss, ‘Don’t Decide Lightly’, Box 2.25 (2), NHC.
This attitude was in stark contrast to Wallace’s, who unquestioningly accepted his patients’ desire for permanent contraception, however Haire’s view prevailed in general throughout the twentieth century – doctors frequently believed that they were better equipped to make this decision than patients themselves.118 Haire was a strong proponent of this belief and asserted his authority accordingly, demonstrated in a case study from 1948: the woman was twenty-four, married with one child, and was pursuing tubal ligation after six illegal abortions and one suicide attempt when she had not been able to procure an abortion.

When she came to see me, I told her I was quite sympathetic, but that, in view of her age, I thought sterilisation unwise, as she might change her mind later on and want a baby… [upon hearing this] at once she became highly emotional. She protested that there was no possible chance of her ever changing her mind about it, and inquired rudely what right I had to set myself up as a judge of whether the operation should be performed or not. I pointed out that I was not attempting to judge whether the operation should be performed or not, but that I was certainly justified in deciding whether or not it should be carried out by me.119

Although Haire maintained that he was not making a judgment on these operations, just whether he would carry them out, he was fully aware that there were few doctors who would operate in these circumstances – illustrating Wallace’s progressive attitude toward his patients’ capability to make their own reproductive decisions. This attitude did not stop Haire from discussing sterilisation extensively in public however, and throughout his career his views on surgical contraception were dependent on the motivation for the operation.

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118 Interview with Stefania Siedlecky, 2 September 2013; Interview with Barbara Simcock, 24 July 2013; Interview with Ian Stewart, 26 November 2013.
119 Wykeham Terriss, ‘A Doctor Looks at Life – Sterilisation as a Last Resort’, Woman, 30 August 1948, Box 2.25 (1), NHC.
In the 1940s, Haire believed that the public were still confused about tubal ligation and vasectomy, as a great deal of uncertainty surrounded both access to these practices, and the legality and safety of sterilisation, whether it be eugenic or contraceptive. Due to public demand, Haire sought to address this knowledge gap in his weekly column ‘A Doctor Looks at Life’, published in *Woman* magazine, which appeared under the pseudonym Wykeham Terriss and discussed all range of matters pertaining to sex. This series was the first of its kind to be run in a mainstream magazine and the question and answer format of the column illuminated the sex lives and sexual concerns of ordinary Australians in the 1940s. Bashford and Strange have analysed the importance of Haire’s work in *Woman*, arguing that in the early twentieth century, popular magazines acted as the primary transmitter of sexual knowledge and sex education to the masses. The column enabled Haire to combine medical and sexual advice in an easily accessible format, the content of which landed *Woman* on a list of publications prohibited by the Catholic Church. In Haire’s opinion, his role was to ‘deal with different aspects of the population problem, advocating the control of fertility in both its positive and negative aspects.’ This differed from the vision of the column held by his editor Guy Natusch, who saw the column as one that would offer readers helpful and informative advice regarding sexual matters. These different visions resulted in frequent disputes between Haire and Natusch, with many of Haire’s proposed columns declared unsuitable, including

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120 Norman Haire, ‘Australia’s Population Problem’, reprinted from *The General Practitioner*, May 1941, Box 7.49, NHC; *J.S.E. February 1952 Questions and Answers*, Box 3.13, NHC; Terriss, ‘Law and Sterilisation’, Box 2.25 (1), NHC.
121 Further information on Haire’s writing in *Woman* magazine can be found in Bashford and Strange, ‘Public Pedagogy’, pp. 71-99 and Wyndham, *Norman Haire and the Study of Sex*, pp. 323-41.
123 Bashford and Strange, ‘Public Pedagogy’, p. 74.
‘Heredity v Environment’ and ‘Church Views on Sex’.\(^{126}\) A public demand for information regarding sterilisation meant that Haire discussed this topic in several articles throughout the 1940s: ‘Many of my readers write asking whether it is possible to be sterilised, whether I would advise them in their particular case to have it done, and how they should set about it.’\(^{127}\) He was often asked for technical surgical details – which he happily supplied – but more frequently, readers wished to learn how they could access these procedures. Haire’s responses to these questions provide significant insight into the distinction that both he and his readers made between contraceptive and eugenic sterilisation in the first half of the twentieth century.

Through these articles it is possible to develop a clear understanding of the framework that Haire used to judge sterilisation requests. In his opinion, there were only two circumstances where sterilisation was unquestionably justifiable: in the case of preventing the transmission of hereditary disease or defect, or when pregnancy would always present a danger to the life or health of the woman concerned – for example if repeated caesarean section had been necessary in previous pregnancies.\(^{128}\) It is important to note here that a large number of children, or the experience of multiple caesarean sections were prevailing regulatory requirements of female sterilisation in this context: the understanding that Australia was an under-populated nation perpetuated the belief that sterilisation for ‘mere convenience’ was selfish and Haire’s attitude was not uncommon – demonstrated in the difficulty that people encountered when trying to access surgical

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\(^{126}\) 1943 correspondence between Norman Haire and Guy Natusch regarding content in Woman magazine, Box 3.4, NHC; However, although some content was deemed unsuitable by his editor, Haire’s weekly column flew under the radar of contemporary censorship and was essentially unregulated, meaning that he was free to publish sex information that was considered to be too explicit in other public forums; Bashford and Strange, ‘Public Pedagogy’, pp. 74-5.

\(^{127}\) Wykeham Terriss, ‘A Doctor Looks at Life – Sterilisation Queries’, Woman, 23 April 1945, Box 2.25 (2), NHC.

\(^{128}\) Terriss, ‘Don’t Decide Lightly’, Box 2.25 (2), NHC.
contraception in this period.\textsuperscript{129} As Haire’s patient records have been lost, it is unclear whether he applied this approach consistently throughout his private practice: however he publicly maintained that he would not operate if the sterilisation request did not conform to these stipulations. This stems from the concept that the intent of the procedure determined its morality and according to the views expressed in Woman, Haire’s sterilisation patients had to prove to him that they deserved permanent contraception. To Haire, cases of heredity were the most deserving of sterilisation: epilepsy, blindness, or the all-encompassing “feeblemindedness”, were all perceived to be valid reasons to operate and in regards to those thought to be “feebleminded”, he believed that sterilisation was preferable to segregation because it would allow them some semblance of a normal life, rather than be confined to an institution – similar to the views expressed by the ESV.\textsuperscript{130} Within Haire’s framework for justification, after heredity and medical grounds, sterilisation could be \textit{considered} if the patient in question was of a low socio-economic status and could not feasibly support any further children:

\begin{quote}
Where a married couple have already had a considerable number of children and feel that further additions to the family would be an intolerable burden on the parents, and would handicap the welfare of those already born…. My own view is that, in cases of this sort, all the circumstances have to be carefully considered before a decision is arrived at.\textsuperscript{131}
\end{quote}

These examples reveal that Haire felt that each individual case for sterilisation required careful consideration of the circumstances before a decision could be made: although his views on sterilisation were subject to change, throughout these case studies he consistently differentiated between operations of hereditary concern and operations of purely

\textsuperscript{129} Haire, ‘Sex Education’, Box 2.1, NHC; Haire, ‘Australia’s Population Problem’, Box 7.49, NHC.

\textsuperscript{130} Haire, \textit{Rejuvenation}, p. 10; Terriss, ‘Sterilisation Queries’, Box no. 2.25 (2), NHC; Terriss, ‘Sterilisation Safeguard’, Box 2.25 (1), NHC.

\textsuperscript{131} Terriss, ‘Don’t Decide Lightly’, Box 2.25 (2), NHC.
contraceptive intent – circumstances of demonstrated real financial hardship remained a grey area. Contextually situated, the regulations that Haire imposed are understandable: however because contraception was not included in official medical education until much later in the century, sterilisation training was passed down through apprenticeship and this extended the lifespan of these early regulatory attitudes. As a result, contraceptive sterilisation remained difficult to access long after the end of Haire’s career. When Haire returned to Australia in 1940, he was amazed to find that little had changed regarding the control of fertility in his absence. ‘The truth is that birth control… is still regarded as something not quite respectable; and contraceptives are sold for prices fantastically higher than their real value, as drinks are at a sly-grog joint.’132 This attitude is demonstrated in the medical training of Stefania Siedlecky, who began her education at the University of Sydney in 1937, entering her first residency at St Vincent’s Hospital as Haire began his career writing for Woman.

**Conclusion: Stefania Siedlecky (1937-50)**

Stefania Siedlecky has had a profoundly significant impact on the history of women’s reproductive health care in Australia. This has been particularly noteworthy in terms of her work regarding access to abortion, but also in her provision of surgical contraception and other health services in both rural areas such as her native Blackheath, and Sydney’s urban landscape. In addition to this, in 1990 she produced one of the seminal texts on the history of birth control in Australia, drawing heavily on her own personal history in this work.133 In 2013 I interviewed Siedlecky, discussing her career from the 1930s-80s, specifically in relation to her experience in the provision of tubal ligation. Her personal history is highly

relevant to the conclusion of this chapter, because while the RHA and the ESV were debating the legality of eugenic sterilisation; while the Church was banning all embodiments of sterilisation amongst the Catholic laity through the platform of *Casti Connubii*; while Wallace was performing contraceptive vasectomies removed from the public eye; and while Haire was airing his opinions on sterilisation in *Woman* magazine, Siedlecky was studying medicine at the University of Sydney and in teaching hospitals throughout Sydney. She was trained in the context of these events and of this discussion, and is representative of the next generation of medical professionals to be involved in contraceptive sterilisation. Siedlecky recalled receiving little instruction on contraception during her university education from 1937-46 – a situation that continued for several decades and perpetuated issues regarding knowledge of and access to birth control.\(^{134}\)

**Stefania Siedlecky:** I remember when I was a student, we asked one of the woman doctors at the time – remember we graduated in war years and girls would be wanting abortions and so on, and we asked one of the woman doctors to give us a talk on contraception – as students nobody mentioned it! And she said, and I’ve quoted this many times, she said “I’m here to teach you how to deliver babies, not how to prevent them!” Full stop. So that’s all the information that we got on contraception.

**Tiarne Barratt:** So was that all the instruction you got during your entire medical degree?

**SS:** [Yes] This was when we were students and I was given the task of asking our tutor to give us a talk on contraception and that’s what she said.

I must say though, we had Bertie Schlink, have you heard of Bertie Schlink? He was a senior gynaecologist, and although he told us about birth control, he

\(^{134}\) Interview with Ian Stewart, 26 November 2013.
said that “flood, famine and disease will see to it that the world is not overpopulated”. Siedlecky graduated in 1943, moving to a residency at St Vincent’s Hospital in Sydney for a year and then to a residency position at Crown St Hospital that she held until 1945. Following these residency terms, Siedlecky started work as Assistant Superintendent at the Rachel Forster Hospital for Women and Children, where she remained until 1948.

Rachel Forster Hospital (RFH) was a hospital founded by women but they didn’t have a birth control clinic – they did run the major venereal diseases clinic. Now I used to think, how is it that it’s alright to run a VD clinic, but you can’t run a birth control clinic – it seems a bit odd. But they had women on the staff at Rachel Forster that didn’t approve of contraception… And it was only some years later when the senior gynaecologist retired did they actually allow birth control at the RFH.

Although the aforementioned conservative lead gynaecologist officially banned contraception, it was at Rachel Forster that Siedlecky learnt how to perform tubal ligation operations – highlighting the authority of individual doctors in an environment that prohibited contraceptive sterilisation, and in turn, the hidden nature of much of this history. She began by assisting more experienced surgeons and by the time she entered private practice in 1949, was able to perform the operation herself, and did so for the rest of her career. However, this was not until patients met certain requirements relating to

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135 Herbert Henry Schlink (1883-1962) was a successful Victorian born gynaecologist, famous for his treatment of pelvic cancer and multiple publications on gynecological diseases. He founded the Royal Australasian College of Surgeons in 1927 and was appointed as a lecturer at the University of Sydney in 1935.

136 Siedlecky was one of the first two female residents to be appointed at St Vincent’s: because the hospital had never before accommodated women, she was required to share a room with the other female resident, which led to complaints from her successors and the result was that only one female resident was appointed from that point onwards, rather than accommodate two women in separate rooms. This was the environment that Siedlecky entered work in, and in this context her contributions to the landscape of women’s reproductive control become all the more revolutionary.

137 Interview with Stefania Siedlecky, 2 September 2013.
their age and number of children, which reveals the lasting influence that doctors from Wallace and Haire’s generation had on new members of the medical profession. As a young practitioner in the 1940s, Siedlecky was taught that it was only appropriate to perform a tubal ligation if the woman’s age, multiplied by her number of existing children, equaled between 90-100: ‘There wasn’t any age requirements, but we had a few sort of odd ideas. One of them was, if you were 30 and you’d had 3 kids, you could have a sterilisation. Then if you were 25, you’d have to have had 4 kids to add up to 90.’ This was not an official requirement, but rule of thumb knowledge and entrenched practice, ‘just one of those things [that everyone knew]…’.\(^{138}\) Despite later criticism of this attitude in \textit{Populate and Perish}, Siedlecky maintained that she refused to sterilise childless women in their twenties as she believed that they would later come to regret the decision, underscoring the reach of this “doctor knows best” attitude within access to surgical contraception.\(^ {139}\)

The unique relationship between eugenics, contraception and sterilisation that has been the focus of this chapter is demonstrated in Siedlecky’s career. This example draws attention to both the clear distinction that was made between these practices based on the intent of the procedure, and to the interconnectedness that stemmed from the same doctors performing both eugenic and contraceptive sterilisation.

\textbf{SS:} The other thing we were asked to do – children of parents, or children who were mentally disabled or defective, their parents would sometimes want them to have a sterilisation, because they were worried that they might get pregnant and the parents would have to have the responsibly of a baby because the mother wouldn’t be capable. And they would come and ask us to sterilise their daughters…

\(^{138}\) Interview with Stefania Siedlecky, 2 September 2013.  
\(^{139}\) Siedlecky and Wyndham, \textit{Populate and Perish}, p. 47.
TB: And what was the protocol, did you do those?

SS: It just depended on the case and also the circumstance. Some mentally disabled women can still have a normal baby – it’s very hard to say. These cases were just considered individually.¹⁴⁰

This excerpt shows that Siedlecky differentiated between her contraceptive work – the ‘women [who] had already had children and didn’t want anymore’ – and the occasional cases of heredity that she encountered throughout her career: an attitude exhibited by all doctors studied for this project, although one that is easily overlooked when the focus is directed at public discussion of sterilisation, rather than private practice. As the twentieth century progressed, attitudes towards birth control became more liberal, the regulatory requirements of sterilisation relaxed, and these practices became more accessible in contraceptive circumstances. This coincided with a number of factors such as the rise of second-wave feminism and changing understandings of gender, increased knowledge and awareness of contraception, developments in surgical technology, and a declining influence of the Catholic Church, all of which contributed to a change in both public discussion and private practices of sterilisation. There was a decline in the prevalence of eugenic ideas and tubal ligation and vasectomy were gradually incorporated into the public healthcare system as viable contraceptive options, in conjunction with a continued history in private practice, which will be demonstrated in chapters three and four.

In the first half of the twentieth century, the same key actors were often involved in eugenics, family planning, and birth control, and for this reason it is frequently perceived that these concepts were inextricably connected. However, this chapter has demonstrated that in the context of sterilisation, analysis of eugenics and contraception not only can, but should be separated, as this separation reveals an underlying history of contraceptive tubal

¹⁴⁰ Interview with Stefania Siedlecky, 2 September 2013.
ligation and vasectomy that continued to influence the global contraceptive landscape into the twenty-first century. Within understandings of sterilisation in the early twentieth century, eugenic and coercive practices were perceived as a contribution to the greater good of society in terms of both the quality and quantity of national populations. In contrast, contraceptive sterilisation was considered in light of the individual, and the way in which permanent contraception would benefit the lives of those couples who underwent the procedure: this distinction explains why doctors held such polarised opinions regarding the circumstances in which sterilisation technology was applied in this period. Thus before sterilisation could achieve widespread notoriety and popularity in a contraceptive context, public opinion first had to embrace the importance of individual reproductive control, marital happiness, and sexual satisfaction – attitudes that began to change in the 1950s and took effect during the “sexual revolution” of the 1960s.
Chapter Three – Sterilisation during the “Sexual Revolution”, 1951-1969

Introduction

The 1950s is a decade in Australian history that has been remembered as a time of moral and political conservatism; an era that witnessed a rise in consumerism and a post-war return to traditional gender roles and family values. Falling between the war years of the 1940s and the “sexual revolution” of the 1960s, the conservatism, prosperity, and stability of the fifties are frequently simplified and exaggerated, the nuances of this period often overlooked.¹ Historians have been working against this stereotype of the 1950s for several decades, yet it continues to characterise popular understandings of the era: demonstrated by the way in which “the fifties” has become an adjective for conservatism and intolerance, in much the same way that “the sixties” continues to remain synonymous with sexual liberation.² Although there were conservative aspects of 1950s culture and politics, these stereotypes disguise the organic nature of social change throughout the twentieth century – the 1950s were a unique and important stepping stone to the revolution of the sixties, rather than a ten year period awash with cultural backwardness and political conservatism.³ The 1950s were marked by recent experiences of war, by memories of the Depression, by Cold War anxiety, by increasing secularisation, international migration, technological advancement, and increasingly progressive understandings of gender and sexuality. In the face of such turbulence, marriage and heteronormativity were carefully monitored and promoted as cornerstones of stability, citizenship, and respectability. These

² John Murphy, Imagining the Fifties: Private Sentiment and Political Culture in Menzies’ Australia (Sydney: University of New South Wales Press, 2000), p. 2.
Throughout this chapter the ‘1950s’ and ‘1960s’ are used to refer to events that occurred within these chronological time periods. In contrast, the ‘fifties’ and ‘sixties’ refer to the idea of these decades in contemporary popular memory.
ideals were intended to mask the anxiety induced by social upheaval in a decade that experienced rising divorce rates and women’s increasing presence in the workforce – not to mention a mounting demand for contraceptive sterilisation – and have facilitated the lingering characterisation of fifties domesticity.⁴

The 1960s are similarly steeped in mythology and legend. Characterised by ideas of individual liberation, “sexual revolution”, counter-culture, radical youth, international protest, human rights struggles, and overarching social transformation that overcame the apparently stifling conservatism of the fifties – the 1960s is a decade that has been ‘heavily edited’ in popular memory.⁵ In relation to contraception, this has been in regards to the conflation of the introduction of the pill and the beginning of the “sexual revolution”, despite a lack of evidence linking these phenomena.⁶ Although the pill has had a huge influence on the contraceptive landscape of the twentieth century, these changes were not instantaneous. Like all transformation in this period, it was gradual, unfolding over the course of many years, and frequently spilling into the 1950s and 1970s – demonstrated in the progressive uptake of contraceptive sterilisation from 1951-69.⁷ The “sexual revolution” frequently dictates discussion of sex in the 1960s: broadly speaking, the term refers to the separation of sex and sexuality from procreation in favour of the pursuit of individual sexual satisfaction and sexual identity.⁸ Although the idea of “sexual revolution” has been exaggerated in many ways, perceptions of sex, gender, and

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⁷ Robinson and Julie Ustinoff, The 1960s in Australia, pp. xi-ii.
reproduction were nevertheless revolutionary in this period.\textsuperscript{9} Public discussion of sex and contraception became less covert, censorship restrictions relaxed, homosexuality had an increased public presence, second wave feminism and women’s liberation originated in this period, and the public profile of issues such as abortion, rape, and sex work were elevated.\textsuperscript{10} In addition, the global connection between family planning and population control achieved unprecedented prominence in this period and facilitated the narrative of individual reproductive freedom that is so often thought to characterise the 1960s.\textsuperscript{11}

The prescribed popular mythology of the fifties and sixties has meant that these decades are subject to a plethora of preconceived ideas about contraception. However the 1950s and ‘60s did not exist in the stark contrast of repression and liberation that is characteristic of popular memory, and the success of these tropes is contingent upon the polarisation of the conservatism of the Menzies era and the radicalism of the “sexual revolution”.\textsuperscript{12} This chapter is not an attempt to address “the fifties” and “the sixties” and all that these terms imply in relation to sex, sexuality, gender, birth control, reproduction and population. Rather it showcases the variety of social, medical, legal, technological, and political change that took place throughout this period and ultimately led to the international popularity of contraceptive sterilisation in the 1970s and ‘80s. The 1950s and ‘60s were a period of great significance in the history of contraceptive sterilisation, as well the history of birth control more generally – the introduction of the pill had an overwhelming impact on both attitudes to and practices of contraception. However the attention paid to oral contraceptives can often mask the underlying narrative of sterilisation

\textsuperscript{10} Bongiorno, \textit{The Sex Lives of Australians}, pp. 222-56.
\textsuperscript{12} Bongiorno, \textit{The Sex Lives of Australians}, p. 186.
in this period: within histories of contraception and sexuality the scope of the project is often determined by the introduction of the pill. This inadvertently creates pre and post-pill narratives and fuels the idea that it is necessary to divide historical analysis of contraception into the first and second halves of the twentieth century. This chronology does not work in the history of sterilisation, as the rise of surgical contraception was gradual and occurred over the course of the twentieth century, making it necessary to view this era as a whole. Throughout this chapter, the analytic frameworks of gender – with an emphasis on masculinity – and religion are employed to challenge existing understandings of contraception in this period. These frameworks are not typically invoked in analyses of contraceptive practice, however they illuminate the public demand for surgical contraception and the full extent of the social change that took place during the 1950s and ‘60s.

In the 1950s, companionate marriage – i.e. marriage based on the mutual consent and equality of both partners – was emphasised in contemporary standards of heteronormativity and as a result, understandings of married relationships began to change: mutual sexual satisfaction was prioritised, women began to take on more of an emboldened sexual persona, and ideal standards of masculinity deemed that men now had to play a role in their families’ emotional happiness in addition to their financial security.

Marriage was held up as the cornerstone of successful society and there was much social

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pressure to conform to these standards of heteronormativity. Changing expectations of marriage, sexual relationships, and gender in the 1950s then had an impact on the public demand for contraceptive sterilisation and it was during this period that discussion of surgical contraception began to move away from the private sphere. This transition to the public sphere continued during the rapid social change and “sexual revolution” of the 1960s. The introduction of the pill signified a shift in women’s public participation in contraception, perceived contraceptive responsibility, and expectations of access to reliable birth control; global concern about overpopulation raised the public profile of sterilisation and the importance of individual reproductive control – neither contraception nor sterilisation had ever before been the subject of such significant media attention; developments in surgical technology meant that doctors became more willing to perform contraceptive sterilisation procedures; and the legal ambiguity that had characterised surgical contraception, and left doctors wary of litigation, was resolved as public opinion became increasingly favourable towards these procedures – by the end of the 1960s contraceptive sterilisation was on the verge of widespread success and availability. As argued in chapter two, the Catholic Church represented the only formalised opposition to the rise of sterilisation; the more prevalent these practices became, the harder the Church fought to suppress them. This attitude continued in the 1960s, demonstrated in the renewed vigour with which contraception was condemned by the papacy, however this position was no longer supported by the laity: the extent of the social change that took place throughout this period is demonstrated in the Australian Catholic laity’s uptake of contraceptive sterilisation practices in the 1960s. On the eve of the 1970s, the surgical, legal, and religious barriers to contraceptive sterilisation had been removed, and individual reproductive control was prioritised in the context of mutual sexual satisfaction and the separation of sex and reproduction that was characteristic of the “sexual revolution”.
Sterilisation and Gender in the 1950s

Experiences, practices, and attitudes towards vasectomy and tubal ligation are as different as the male and female body; ideal standards of masculinity and femininity are equally different. Regardless of this difference, changing understandings of gender and sexuality similarly influenced the increased public demand for both male and female sterilisation as the twentieth century progressed. For example, expectations of masculinity underwent significant change throughout the 1950s. Marriage was promoted as the cornerstone of society, yet with new demands made on men as husbands and fathers. In addition to providing physical and financial care, there was now the added expectation that men had to take responsibility for the mental and emotional care of their families if they were to ensure overall happiness and wellbeing.\(^{16}\) The new emphasis on companionate marriage meant that male sexual pleasure ceased to be the sole marker of successful heterosexual sex, and mutual sexual satisfaction within married relationships was prioritised – a postscript to Marie Stopes’ *Married Love*, and a prelude to the “sexual revolution” of the sixties.\(^ {17}\) However these additions did not threaten men as the head of the family unit, they simply added to the requirements of ideal masculinity – the contextual “breadwinner” identity.\(^ {18}\) These new perceptions of masculinity led to an increased demand for Victor Hugo Wallace’s vasectomy services during this period: out of the surviving patient records in the Wallace archive, approximately seventy-five per cent of documented vasectomy operations took place in the 1950s, the majority of which reveal an awareness of “breadwinner” masculinity and an expectation to succeed at this identity.\(^ {19}\)

Throughout the twentieth century, the relationship between vasectomy and masculinity has been complex and often contradictory, fuelled by an overarching

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association with castration: the operation is paradoxically perceived as the ultimate threat to masculinity, and the ultimate expression of masculinity. From one perspective, vasectomy was perceived to remove the recipient’s potential to engage in procreative sex and with it, expressions of manhood directly related to sexual dominance and prowess. In direct competition with this emasculating and threatening perception of sterilisation, was the idea that manhood can be proved and reinforced through vasectomy. Within this mindset, vasectomy represented the ultimate sacrifice – surrendering procreative competency to protect a partner, and in some cases existing children, from the possibility of further pregnancy – a gesture that signified putting one’s family ahead of personal fears. In light of the new emphasis placed on sexual satisfaction and safeguarding the happiness of one’s wife and children, vasectomy was viewed increasingly favourably as the anxiety created by fears of an unwanted pregnancy often stood in the way of the realisation of these goals. Although these conflicting ideas continue to characterise discussion of male sterilisation, the pervasive influence of changing understandings of masculinity in the 1950s signified the beginning of a less threatening, popularised perception of vasectomy that was crucial

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18 Murphy, *Imagining the Fifties*, p. 35.
19 Of the 230 case studies available, 176 of the operations occurred between the years from 1950 to 1960, see Figure 3.1. Note that Wallace performed approximately 100 more vasectomies than there are records available: letters indicate that this trend continued after the 1950s and that these operations took place in the 1960s; Vasectomy Patient Records, Boxes 63 and 65, Victor Hugo Wallace Collection, University of Melbourne Archives [hereafter VHWC]; Bongiorno, *The Sex Lives of Australians*, p. 186.
20 Gilbert Kasirsky, *Vasectomy, Manhood and Sex* (New York: Springer Publishing, 1972), pp. 39-42. Located in Wallace’s female contraceptive patient records, there are several examples where he recommended male sterilisation in the interests of the woman, for this option to then be rejected by husbands who did not want to undergo vasectomy. This demonstrates the strength of male anxieties associated with the operation, even in the face of the ideal 1950s masculinity; ‘Patient History Cards Concerned with Contraception 1947-72’, Box 65.B, VHWC.
to its contraceptive success: in twenty-first century Australia vasectomy is now one third more popular than tubal ligation as a result of this shift in attitudes.\textsuperscript{22}

Victor Hugo Wallace was an integral figure in the Australian narrative of contraceptive sterilisation: spanning five decades (1934-76), his vasectomy career problematises the perception that sterilisation practices were eugenic in the first half of the twentieth century and contraceptive in the second half, and instead reveals that these practices coexisted. Additionally, his work challenges the idea that histories of birth control should focus solely on the experiences of women – namely the introduction of the pill in 1960 – and demonstrates that a parallel consideration of masculinity via vasectomy is needed. Wallace’s records from the 1950s support the argument made by Kate Fisher in \textit{Birth Control, Sex and Marriage}, that for much of the twentieth century, contraception was a male responsibility – an idea that is now frequently overlooked.\textsuperscript{23} Drawing heavily upon oral testimonies, Fisher contends that prior to the 1960s, British women were often content to let their male partners bear the responsibly of birth control.\textsuperscript{24} This was a context in which contraceptive responsibility was conflated with manhood and for the most part, women only became involved in contraceptive matters when their husbands failed or neglected to fulfil this duty.\textsuperscript{25} Prescribed gendered sexual personae of this period prized male action and female passivity and discussion of sex and reproduction tended to embarrass women, as these things fell outside the domestic, maternal sphere.\textsuperscript{26} In a recent


\textsuperscript{23} Fisher, \textit{Birth Control, Sex, and Marriage}, pp. 238-9.

\textsuperscript{24} Fisher, \textit{Birth Control, Sex, and Marriage}, pp. 219, 226.

\textsuperscript{25} Fisher, \textit{Birth Control, Sex, and Marriage}, pp. 193-4, 202-3, 225.

\textsuperscript{26} Fisher, \textit{Birth Control, Sex, and Marriage}, pp. 189-91, 209-12.
interview, Stefania Siedlecky argued that the female embarrassment traditionally associated with sex began to dissipate when the pill became widely available, her evidence being an associated increase in requests for tubal ligation in the 1960s. However there were exceptions to Fisher’s argument, as there were women who transgressed this mould and actively pursued contraceptive sterilisation in the 1950s, despite being in happily married relationships. Regardless of these exceptions, the perception that contraceptive responsibility was intrinsically linked to successful performances of masculinity in the 1950s is apparent throughout Wallace’s vasectomy records and an awareness of the “provider” identity is particularly dominant in the majority of these patient records.

![Figure 3.1](image_url)

Figure 3.1 V.H. Wallace Vasectomy Patient Chart based on patient records from the Victor Hugo Wallace Collection held at the University of Melbourne Archives.

As discussed in chapter two, the idea of “breadwinner” or “provider” masculinity is often considered to be characteristic of the post-war, consumer driven society of the 1950s. In order to be considered financially comfortable and successful in this period, certain

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27 Interview with Dr Stefania Siedlecky by Tiarne Barratt, 2 September 2013.
28 Anonymous question submitted to Norman Haire via the *Journal of Sex Education*, ‘J.S.E. February 1952 Questions and Answers – Copy’, in *Journal of Sex Education* (Articles), Box 3.13, Norman Haire Collection, University of Sydney Rare Books Collection [hereafter NHC].
levels of consumerism were expected and as articulated by Johnny Bell, ‘…for the working and middle class alike, the worth of fathers in the fifties was inevitably bound up with the rewards and demands of a growing consumer society.’\(^{29}\) This provided further incentive to limit family size, as there was a duty to have children, but not more than a couple could adequately support. This attitude is reflected in Wallace’s vasectomy patients, for example the couple who felt that they had fulfilled their obligation to society by having seven children and desired a vasectomy due to financial considerations.\(^{30}\)

Similarly, Wallace operated on William Clarke – an engineer, husband, and father of four sons – in 1952. Clarke was thirty-seven at the time and provided the following information, indicating an awareness of his prescribed masculine duty to both protect his wife’s health, to consult her regarding major decisions, and to provide economic security for his family:

> We the undersigned being man and wife and parents of four sons, have decided, after long and intelligent consideration, to take steps to ensure that we have no more issue. Our reasons for this decision being: Firstly, the wife’s prolonged sickness during the whole period of her last two pregnancies culminating in kidney trouble in the final stages on both occasions. Secondly, for economic reasons, as we desire to give our four boys a reasonable education, and feed and clothe them in a decent manner.\(^{31}\)

The men undergoing vasectomy in the 1950s had in many cases lived through the Depression and one, if not two, world wars – experiencing firsthand the economic strain of multiple pregnancies during their formative years. Although this era is depicted as one of economic success and stability, for many, memories of hardship remained fresh and for the working classes, hardship remained a daily reality when navigating the ongoing difficulties

\(^{29}\) Bell, ‘Putting Dad in the Picture’, pp. 905-7, 917.

\(^{30}\) Vasectomy patient letter of consent, 5 September 1959, Box 65.A, VHWC.

\(^{31}\) Vasectomy patient letter of consent, William Clarke*, 22 September 1952, Box 65.A, VHWC.
of a post-war economy. Mark Peel has contended that these were the men who most strongly identified with the “breadwinner” understanding of masculinity in the 1950s: he argues that their sense of satisfaction and self-respect came from providing for their families, succeeding in this role in a way that their fathers had been unable to during the Depression. One way that men expressed this duty was through responsibility for contraception, of which vasectomy became an increasingly popular option as the twentieth century progressed.

In the 1950s, understandings of the “provider” role associated with successful masculinity in Australia underwent a transformation – for the first time, the role encompassed both physical and emotional care. Many of Wallace’s patients acted in accordance with this new identity, apparent in their reasons professed for undergoing vasectomy. This is encapsulated in the succinct statement of Edward Kent: ‘I am requesting a vasectomy operation for the reason that I feel that my present family of three boys is quite sufficient for my wife and I to cope with without impairing her health, and for the happiness of all concerned.’ Kent was forty-one at the time of his vasectomy and his actions satisfy the expectation that in order to be a good provider, he had to take responsibility for the health and happiness of his family – expressed here in his decision to be sterilised. This consideration of familial happiness is similarly conveyed in the patient record of John Greene: forty and the father of four children, his wife had had two nervous breakdowns to date, which were intensified by the responsibilities of motherhood. In order to ensure that they would be guaranteed complete liberation from conception, both Greene and his wife were sterilised – his wife at the Royal Melbourne Hospital, and himself in

35 Vasectomy patient letter of consent, Edward Kent*, 29 August 1951, Box 65.A, VHWC.
Wallace’s private practice. At first it may appear curious that men were so willing to bow to the ideal the standards of masculinity espoused in this period, particularly given that the reality of the suburban dream was deeply unsatisfying for many who achieved it. However, this was a period in which normality was prized, indeed demanded, and there was considerable pressure to conform to social norms – demonstrated in the intimidating consequences of deviation, namely the fierce persecution of homosexuality. In a post-war society that relied on consumerism and the appearance of stability, the institution of marriage was imperative to success, and performances of masculinity were under scrutiny and surveillance, all of which contributed to contemporary understandings of manhood and a gradual move towards contraceptive vasectomy in this period.

Within the institution of marriage, a very specific type of socially acceptable sex and sexual identity was enforced in the 1950s. There was a new emphasis on companionate marriage and mutual sexual satisfaction, which both Lisa Featherstone and Frank Bongiorno have argued, induced anxiety in many individuals regarding their sex lives – seen in the wide array of patients that Wallace saw for sexual counselling in this period. The goal of mutual pleasure created the perception that a man had failed in his performance of masculinity if he was unable to sexually satisfy his wife. This contributed to the rising demand for vasectomy services: the operation was employed to alleviate fears of unwanted pregnancy, and subsequently facilitate female sexual pleasure. Edmund

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36 Vasectomy patient record, John Greene*, 12 January 1959, Box 65.A, VHWC.
37 Featherstone, *Let’s Talk About Sex*, pp. 229-34.
38 Graham Willett, ‘The Darkest Decade: Homophobia in 1950s Australia’, *Australian Historical Studies* vol. 27, no. 109 (1997), pp. 120-9. Wartime circumstances had put considerable strain on married relationships and although marriage rates were booming by the 1950s, divorce rates remained high and there was a continued need to police married relationships, seen in treatment of sex and sexuality in this period; Murphy, *Imagining the Fifties*, p. 1; Bongiorno, *The Sex Lives of Australians*, pp. 200-1.
Cartwright displayed evidence of this in his reasons given for desiring a vasectomy in 1953:

Our reasons for wanting the vasectomy are a). We are both now of an age where a further family addition would not be desired. b). We find the constant precautions are proving too much for our nerves and we feel that we should now be free of worry and be able to pursue a happy sexual liaison.40

At forty-three, Cartwright and his wife wished to enjoy the harmonious, mutually satisfying sexual relationship advertised in contemporary standards of social normalcy. The potential burden of unintended conception often led to tense marital relations, as was expressed by one of Norman Haire’s female patients in 1952: ‘the fear of an un-wanted pregnancy keeps worrying me, with the result that I become irritable with my husband and put him off, which makes us both unhappy.’41 Indeed one of the reasons the pill has been remembered as ground breaking was because of its potential to facilitate anxiety-free female pleasure. This new ideal of mutual pleasure within marriage also altered understandings of female sexuality: women could now be sexual and have an active sexual identity without sacrificing their respectability as a wife or mother, which in turn had an impact on rising rates of tubal ligation as increasing acceptance of female sexuality further justified permanent voluntary infertility.42

Despite the social pressure, not all men were determined to conform to the conventions of provider masculinity and this identity was in competition with that of “bushranger masculinity”. The bushranger figure represented older understandings of

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41 Anonymous question submitted to Norman Haire via the Journal of Sex Education, February 1952, Box 3.13, NHC.
42 As there was an increasing separation of sexual pleasure and reproduction, it became socially acceptable to desire contraceptive sterilisation so that an enjoyable sexual relationship could be pursued – the very thing that Norman Haire had feared less than three decades earlier; Vasectomy patient letter of consent, 15 June 1956, Box 65.A, VHWC; Norman Haire, ‘Birth Control’, in Norman Haire eds., Some More Medical Views on Birth Control (London: Cecil Palmer, 1928), p. 48.
Australian masculinity and had historical ties to ANZAC and wartime perceptions of manhood – he was a figure suffocated by marriage and family life. However rather than pose a challenge to the increasing popularity of vasectomy, this divergent masculine identity contributed to it: these men wished to reject fatherhood entirely, and did so through permanent sterility. Wallace had several childless vasectomy patients in the 1950s, for example, twenty-one year old George Hanna, who submitted to vasectomy on the eve of his wedding because ‘for a long time he ha[d] desired to have no children. Vasectomy done.’ Or Paul Jones, a single man of thirty-four years, working as a musician with no real desire to ever marry or have children, and accordingly sought out Wallace’s sterilisation services in 1950 – although both men would have had their sterilisation requests rejected if they had encountered Haire rather than Wallace. These men demonstrate rejection of the social expectation to father children, and in Jones’ case, to conform to a heteronormative relationship and accompanying lifestyle. Ross Laurie has argued that men’s magazines of the 1950s rejected the concept of “provider” masculinity, depicting care for a partner and children as emasculating – a threat to manhood rather than a pillar of its success. Yet although these narratives of masculinity were in competition with one another, the dominance of normativity and the “breadwinner” identity succeeded, fuelling rates of vasectomy, both in men’s compliance with this persona, and in their rejection of it. Though a multitude of other factors contributed to the overall rise of contraceptive sterilisation, most of which took effect in the 1960s – including the separation of sex and reproduction and international fears regarding overpopulation and

44 Vasectomy patient record, George Hanna*, 24 December 1952, Box 65.A, VHWC.
45 Vasectomy patient record, Paul Jones*, 27 March 1950, Box 65.A, VHWC.
47 Murphy, Imagining the Fifties, pp. 33-4.
world resources – the particular influence of masculinity lends insight into individual experiences of surgical contraception and the position of men in the history of birth control more generally. This inclusion of male experience does not take away from the centrality of women in the history of birth control. Instead it draws attention to the gendered interaction that characterises the need for contraception – women’s experiences of reproduction do not take place in a state of isolation that is intrinsically separate from their male partners, so neither should the history of reproduction.

If changing understandings of gender, marriage, and sexuality had such an impact on the public demand for vasectomy, how did these ideas then affect women and the popularity of tubal ligation in the 1950s? In contrast to records of vasectomy in this period, there are comparatively few surviving patient records of tubal ligation amongst the records of Haire, Wallace, or Siedlecky. In the same way that the “breadwinner” was the socially prescribed masculine identity of this period, the “homemaker” identity was held up as the ideal feminine counterpart. Jessamyn Neuhaus has argued that this ideal standard of femininity reflected post-war anxieties relating to the rapid social change that was taking place, in particular women’s increasing participation in the workforce.48 Indeed many who “succeeded” in this identity were deeply unsatisfied with its reality – even the cookbooks instructing how to be the perfect housewife had to acknowledge that women had interests outside the kitchen.49 Thus the compliant “homemaker” persona was not an accurate reflection of women in this period, which can be seen in the increasing presence of tubal ligation on the Australian contraceptive landscape in the 1950s.50 This signified women

50 Gigi Santow, ‘Trends in Contraception and Sterilization in Australia’, *The Australian and New Zealand Journal of Obstetrics and Gynaecology* vol. 31, no. 3 (1991), p. 203; though data from the 1950s is limited in this study, the results reveal that women in their mid-twenties were using contraceptive tubal ligation in 1956, which points to changing attitudes of acceptance and strongly suggests that women in the 30–45 age group were now using this method more frequently than their younger counter-parts.
taking contraceptive matters into their own hands as a result of the increasing acceptance of female sexuality, which had implications in relation to the prescribed gendered responsibility of birth control: by the 1960s the male responsibility that had characterised contraceptive practice in the twentieth century had been replaced by the attitude that birth control was a woman’s domain. Although attempts to live up to ideal standards of masculinity in the 1950s signified the beginning of the end of male castration anxiety – arguably the biggest hurdle to be overcome in male acceptance of vasectomy – the same cannot be said for women’s experiences in this period. In contrast, women’s use of tubal ligation appears to have been less connected to ideal standards of femininity and more reliant upon an increased confidence when it came to demanding access to contraception: this became an increasingly widespread reality in the 1960s and ‘70s in response to the pervasiveness of the women’s liberation movement, the “sexual revolution”, and the introduction of the pill.\textsuperscript{51} Additionally, the surgical technology of the 1950s was not conducive to medical support for contraceptive tubal ligation and this too altered later in the twentieth century.

Lisa Featherstone has argued that the 1940s were a turning point for female sexuality and attitudes towards birth control. Upon analysis of the 1943-44 survey of Wallace’s contraceptive patients, she stated that ‘…women a generation or two earlier might have simply resorted to abstinence… But for these women in the 1940s, abstinence was no longer an option.’\textsuperscript{52} The women she refers to used contraception because their repeated refusal to engage in intercourse had created marital problems and challenged the perceived male entitlement to sex within marriage. During the 1940s, the separation of the ‘wife’ and ‘mother’ persona began to occur and this was a period of transition for the

\textsuperscript{51} Interview with Stefania Siedlecky, 2 September 2013.
\textsuperscript{52} Lisa Featherstone, ‘Sexy Mamas?: Women, Sexuality and Reproduction in Australia in the 1940s’, \textit{Australian Historical Studies} vol. 36, no. 126 (2005), pp. 242-4.
institution of marriage: in addition to wartime complications, successful womanhood was no longer based entirely on good parenting skills. Women now had to be attentive and attractive wives, separate from their mothering roles. A decade later, new understandings of sex within married relationships had developed out of the 1940s separation of parental and spousal relationships, demonstrated in the 1950s move towards companionate marriage and mutual sexual satisfaction. However, these changes did not represent a real challenge to the scope or dominance of male authority within family life, and the majority of feminist thinkers in the 1950s agreed that the discrimination women experienced was based on the overarching belief of masculine superiority. In spite of this, traditional gendered and sexual dynamics were changing and attitudes towards contraceptive sterilisation reflected this: the 1950s were not the period of sexual repression that popular memory makes them out to be, but instead witnessed the beginning of the contraceptive and sexual revolutions that were fully realised in the 1960s and 1970s.

In 1952, Lucy Walker – a happily married woman and mother of two living in far-north Queensland – wrote to Norman Haire through the Question and Answer section of the Journal of Sex Education. Although tubal ligation and vasectomy were gradually becoming more popular, a degree of mystery still shrouded these operations and Walker sought advice regarding access:

My husband and I were very interested in your articles on Sterilisation which appeared in the Australian magazine WOMAN a year or so ago. We have two children and are both agreed that we do not want any more. And, although I try to ignore it, the fear of an un-wanted pregnancy keeps worrying me, with the result that I become irritable with my husband and put him off, which makes us both unhappy. We have been living in the far north of Australia for the last

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55 Shira Tarrant, ‘When Sex Became Gender: Mirra Komarovsky’s Feminism of the 1950s’, Women’s Studies Quarterly vol. 33, no. 3 (2005), p. 335; Murphy, Imagining the Fifties, p. 35.
four years, but I shall soon have to go South on business, and we wondered if, while I was down there, you could let me know the best way to go about having the operation, and some idea of the cost. Whom should I approach? Are there specialists in this particular field? We have only government doctors up here.\textsuperscript{56}

This letter demonstrates that in the 1950s, contraceptive sterilisation was still largely unregulated and dependent upon the cooperation of individual doctors as she chose to write to Haire in England, rather than consult her local doctor – whom she implied harboured a conservative attitude toward tubal ligation. But more than that, Walker’s letter reveals an independent woman who was confident in taking control of her fertility and sexual identity – a far cry from the idealised “homemaker” persona of the era. In contrast to her 1940s counterparts, Walker sought contraception because she wanted to engage in worry-free sex, not simply to meet the demands of her husband, but for the sake of their mutual happiness. This was in line with contemporary perceptions of marital sexual relations, and this increasing acceptance of female sexuality contributed to a concurrent demand for tubal ligation that continued in the 1960, ‘70s, and ‘80s as women became increasing liberated from their earlier confinement to the private, domestic sphere.

These examples of tubal ligation and vasectomy reveal that many of the ideas associated with the “sexual revolution” of the sixties actually had origins in the 1950s – a decade allegedly characterised by its conservatism and sexual backwardness.\textsuperscript{57} Although contraceptive sterilisation did occur earlier in the twentieth century, it was during the 1950s that attitudes towards this practice began to alter. As the importance of sexual

\textsuperscript{56} Anonymous question from Lucy Walker* submitted to Norman Haire via the \textit{Journal of Sex Education}, February 1952, Box 3.13, NHC.

relationships was acknowledged, social perceptions of gender and sexuality became increasingly accepting of individual reproductive control; the pill was in early stages of development; and the need for reliable, readily available contraception started to become internationally recognised in the context of perceived overpopulation. From the late 1950s onwards, the global press began to report concerns of the increasing world population, and the idea of a population “bomb” or a population “explosion” permeated discussion of birth control in this period – a solution to population growth. The growing popularity of contraceptive sterilisation was dependent upon various technological, medical, legal, and political developments, many of which had roots in the 1950s and became more prominent in the 1960s. By the 1970s there was little in the way of opposition to surgical contraception – even the Catholic community had begun to partake – and in light of the rapid social change of the 1960s, doctors had little choice but to accept the public demand for these services.

The 1960s – A Period of Rapid Change

The 1960s was the decade that propelled sterilisation from its covert contraceptive status, to a highly sought after, public, and readily accessible method of birth control in the late 1970s and early 1980s. Technology advanced, legal ambiguity disappeared, and Australian medical professionals became increasingly likely to perform contraceptive sterilisation as the 1960s merged into the 1970s. This transformation can be attributed to the unique context of the 1960s. It was an era of “sexual revolution”, of women’s liberation, and of

the introduction of the pill: but in addition to this, it was an era of rising global population concerns, characterised by the “population explosion” and the marriage of family planning and international population control programs.\(^{61}\) Combined, these factors facilitated the ongoing contraceptive popularity of tubal ligation and vasectomy, not just in Australia, but around the world.\(^{62}\) In relation to contraceptive sterilisation in Australia, the use of female procedures increased at a much faster rate than male procedures in this period: as women became increasingly confident participating in public discussion of contraception, the demand for these procedures amplified and surgical contraception was increasingly accepted within the medical community.\(^{63}\) The “sexual revolution” is an ambiguous term – the exact meaning and effect of which is still debated, particularly in relation to contraception – and it typically refers to the increasing separation of sex and procreation witnessed in the 1960s.\(^{64}\) Sexuality entered the public sphere and traditional understandings of gender were called into question: sex, gender, and sexuality became fluid concepts to be explored, expressed, and enjoyed.\(^{65}\) In 1963, in a now canonical text, Betty Friedan urged women to break out of ‘the feminine mystique’; to establish themselves in the public sphere; to combat their oppression – a ‘problem that has no name’.\(^{66}\) But although these ideas have come to characterise the 1960s, the increasing liberation of women was a source of anxiety for many and a threat to masculinity, which is


\(^{63}\) Santow, ‘Trends in Contraception and Sterilization in Australia’, p. 205; Interview with Stefania Siedlecky, 2 September 2013.


reflected extensively in contextual popular culture films and television shows – and perhaps in the faster uptake of tubal ligation in comparison to vasectomy in this period.\textsuperscript{67}

In 1960 the Racial Hygiene Association of NSW became Family Planning NSW – a symbol of the contraceptive transformation of the 1960s.\textsuperscript{68} With this rebranding, the organisation expanded and extended the services offered: one doctor fitting diaphragms in the mid-1950s was replaced with a specialised medical staff, who provided an array of birth control options, including oral contraceptives and referrals for tubal ligation and vasectomy.\textsuperscript{69} Stefania Siedlecky was a key member of Family Planning throughout her career, and in turn, Family Planning played an integral role in the uptake of contraceptive sterilisation, its members consistently advocating for better access to reproductive healthcare. The Australian women’s health movement, an offshoot of the broader women’s liberation movement of the 1960s, was concerned with increasing women’s access to healthcare and worked with state governments to do so, apparent in the increasing presence of government subsidised sterilisation procedures.\textsuperscript{70} In spite of her conservative medical education under Wallace and Haire’s contemporaries, Siedlecky’s subsequent career demonstrates the changing context of the 1950s and ‘60s: she operated a successful private practice throughout the 1950s where she performed contraceptive tubal ligation; she held a number of authoritative gynaecological positions in Sydney throughout the 1960s; she founded the Leichhardt Women’s Health Centre in 1974; and she was the


\textsuperscript{68} In addition to this, the Eugenics Society of Victoria disbanded in 1961, both of which demonstrate the end of Australian eugenic organisations, however not the end of eugenic ideas – many of which continued in relation to medical views on sterilisation; ‘The Case for Eugenic Sterilization’, \textit{The Medical Journal of Australia} vol. 2, no. 5 (1967), pp. 219-20.

\textsuperscript{69} Siedlecky and Wyndham, \textit{Populate and Perish}, pp. 30-1; Interview with Dr Barbara Simcock by Tiarne Barratt, 24 July 2013.

senior adviser in women’s health at Family Planning NSW in the late 1970s. Her career was ground breaking for someone of her class and gender – contributing to change as much as being a product of it. Shirra Tarrant has argued that the current way in which the history of feminism is viewed – as occurring in various “waves” – is limiting as it bypasses the scope and impact of feminist activity in other less publicised periods, for example Siedlecky’s work in the 1950s and early 1960s. Tarrant contends that the women’s liberation movement and the rise of second wave feminism did not occur in isolation, but had roots in the 1950s and early 1960s, despite a perceived “lack” of activity in this period and despite a perceived generational change.\(^\text{71}\) The feminism of the late 1960s and ‘70s was distinct from Australian feminisms that had come before it: a product of the sexism experienced in anti-war movements, women sought equality and a higher status for all women, with a strong emphasis on sexual rights and freedoms.\(^\text{72}\) This fuelled public discussion of sex and contributed to an increased public demand for contraceptive tubal ligation.

Additionally, population control is a central element in the international history of contraceptive sterilisation, as concern regarding overpopulation raised the public profile of sterilisation in the second half of the twentieth century and this influenced the rise of its contraceptive popularity throughout Australia.\(^\text{73}\) Beginning in the 1950s – and continuing in the 1960s and ‘70s – as population growth began to outstrip food supply, there was a mounting Malthusian-style fear that the world’s resources were ill equipped to sustain its ever-increasing population.\(^\text{74}\) International security and stability were thought to be

\(^{71}\) Tarrant, ‘When Sex Became Gender’, pp. 334-5.


\(^{73}\) Due to time constraints and a focus on practices of tubal ligation and vasectomy in Australia, population control is considered in brief in this thesis; for detailed discussion of this international phenomenon in the twentieth century see: Bashford, *Global Population*; Connelly, *Fatal Misconception*; Robertson, *The Malthusian Moment*.

threatened by overpopulation and food shortages, and this resulted in a concurrent rise in support for family planning programs – the previous perceived immorality of contraception overshadowed by fears of population growth. It was predicted that unchecked population growth would result in political and economic instability, culminating in a global resource shortage. Although the birth rate in Western countries was perceived to be relatively satisfactory, the birth rate in developing countries was seen to be far too high, and in light of Cold War anxieties this disparity was interpreted as threatening – a potential pathway to the rise of Communism and the downfall of Western consumerism. In the context of the population “bomb” or population “explosion”, birth control, family planning, and population control were used interchangeably, so interconnected were these concepts and at a political level, birth control was no longer considered a ‘question of individual health or preference’, but a matter of global welfare. As a result, historical understandings of post-war global contraceptive politics often separate the ideas of reproductive “freedom” typically associated with the introduction of the pill and the “sexual revolution”, from coercive population control programs. In Global Population, Alison Bashford argues that the polarisation of reproductive freedoms and population control is misguided, and that historically, these narratives were intimately connected. As the twentieth century progressed, coercive tactics came to be considered counter-productive to the realisation of global population control. Instead, its political supporters reframed population policies to reflect the idea of reproductive freedom and an

individual desire to control fertility.\textsuperscript{79} The ‘necessity of voluntary family planning’ was perceived as crucial to successful population management and this too had an impact on attitudes towards contraceptive sterilisation in Australia.\textsuperscript{80}

In this context, aims to limit population growth and to provide individual reproductive freedom were closely aligned and this is apparent in the careers of Australian vasectomy doctors Victor Hugo Wallace, Bruce Errey and Barbara Simcock.\textsuperscript{81} In addition, their careers highlight the relationship between Indian family planning programs and the availability of contraceptive sterilisation in Australia. In 1957, Wallace edited the volume \textit{Paths to Peace} in which he offered ‘a world population policy’ as one such pathway. His focus was the availability of reliable birth control in order to limit population growth and relieve subsequent pressures related to food and natural resources:

Since a species has the capacity to increase in numbers more rapidly than food can be made available to support the increased numbers, population growth should be restricted. Facilities for planned parenthood should be made available to all peoples as quickly as possible. The danger of war will be diminished if population pressure is relieved.\textsuperscript{82}

Neither Wallace, Errey nor Simcock concealed their concern about overpopulation and the influence that it had on their vasectomy careers – these concerns did not need to be hidden as population control and sterilisation were yet to be conflated with coercive eugenics.\textsuperscript{83} Though this thesis predominantly focuses on individual experiences of contraceptive sterilisation, it is important to bear the impact of population control in mind when


\textsuperscript{81} Interview with Dr Bruce Errey by Tiarnne Barratt, 15 January 2014; Interview with Barbara Simcock, 24 July 2013.


\textsuperscript{83} Leslie Murphy, ‘Riots Mar India’s Mass Sterilisation Campaign’, \textit{The Age}, 2 December 1976.
exploring the “sexual revolution”, individual reproductive freedom, and the rise of contraceptive sterilisation in the 1960s. These politics were pervasive and had a considerable influence on public awareness of these procedures, creating a subsequent demand and thereby vastly increasing their availability.\(^8^4\)

In a recent interview, Siedlecky attributed the rise of contraceptive tubal ligation in the 1960s to two things – developments in laparoscopic technology and the introduction of the pill in 1961.

**Tiarne Barratt:** Throughout your career, what were the biggest developments in terms of birth control and sterilisation?

**Stefania Siedlecky:** I suppose surgical developments in sterilisation – so much simpler these days – but I think the pill’s the most important thing… Because, well no one ever talked about it [contraception] before the pill, it never appeared in the paper, it changed the whole world as far as contraception was concerned.\(^8^5\)

Hera Cook has argued that the centrality of technology in the history of birth control should not be overlooked, as technology shapes change and determines access.\(^8^6\) This was certainly the case with tubal ligation. As argued in chapter one, laparoscopic or “keyhole” surgery was ground breaking in relation to the efficiency of tubal ligation procedures, both in terms of reduced operating time and reduced recovery time: the introduction of the laparoscope meant that tubal ligation no longer constituted major open surgery.\(^8^7\) These developments made the operation less demanding and thus more accessible to women who sought permanent contraception, as doctors became increasingly inclined to perform

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\(^8^4\) Interview with Barbara Simcock, 24 July 2013; Interview with Bruce Errey, 15 January 2014.

\(^8^5\) Interview with Stefania Siedlecky, 2 September 2013.


contraceptive tubal ligation. However it is intriguing that Siedlecky remembers sex and contraception as absent from public discussion prior to the 1960s: they were of course present, for example Norman Haire’s column in Woman magazine. It is therefore likely that the change Siedlecky recalled was instead the way in which discussion of contraception became less censored and less covert after the introduction of the pill. It was certainly the case within The Medical Journal of Australia that the development of the pill resulted in a significant increase in medical discussion of contraception, both oral and surgical. In the context of the women’s liberation movement and the increasing uptake of the pill, women became more confident in discussing contraception with their doctors, and access to reliable contraception was becoming an expectation rather than a privilege – all of which facilitated a rise in requests for tubal ligation procedures, accounting for the importance that Siedlecky attributed to oral contraceptives throughout her career.

The Medical Journal of Australia (MJA) showcased Australian medical opinion and peer discussion, documenting the gradual acceptance of contraceptive sterilisation within this community in the 1960s and ‘70s. Motivated by reader demand, the MJA broke its previous silence on sterilisation in 1963 when it published a feature article on the ethics and legality of this practice: the article sparked a flurry of reader responses, demonstrating that contraceptive sterilisation was emerging as a distinct phenomenon by

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91 Interview with Stefania Siedlecky, 2 September 2013; Robertson, The Malthusian Moment, p. 157.
92 Throughout the 1960s and ‘70s, The Medical Journal of Australia received much correspondence from doctors throughout the country related to contraceptive sterilisation, discussing everything from personal opinion, to an exchange of techniques and the differences between tubal ligation and vasectomy.
the early 1960s. Rather than offer an individual opinion via an editorial, the journal presented a variety of contemporary viewpoints and ultimately supported the conservative Australian Medical Association (AMA), concluding that:

…we doubt if most doctors would want to deviate from the ethical views expressed by the New South Wales Branch of the Australian Medical Association… and their right to adhere to this view must be respected, whatever the views of their colleagues or the requests of their patients.

This statement indicates that contraceptive sterilisation was becoming increasingly accepted by many members of the Australian medical community and that more and more patients were putting pressure on their doctors to perform these procedures. This position was at once an acknowledgement of the increasing public demand for surgical contraception, and a firm rejection of this trend, as in 1963 the AMA continued to advise that sterilisation was illegal. This view was met with mixed reviews as some doctors supported a continued rejection of surgical contraception, while others hoped ‘that the Australian Medical Association [would] come down from its ivory tower and reconsider its attitude to sterilization operations.’ However after this initial flurry of discussion, the MJA fell back into silence regarding contraceptive sterilisation until 1967 when Perth doctor W.S. Haynes contributed an article advocating the benefits of contraceptive vasectomy. This article was followed shortly after by an overview of eugenic sterilisation in Australia – in which a clear distinction between eugenic and contraceptive procedures was made. Haynes argued that ‘if this operation [vasectomy] was freely available, it would constitute the most attractive contraceptive method to a firmly united couple who

have had as many children as they desire.’ This indicates that sterilisation was gaining popularity and notoriety on the contraceptive landscape, but that in order for this to succeed, a significant shift in medical attitudes was necessary. This is particularly discernible in Victor Hugo Wallace’s response to this article: Wallace strongly supported Haynes’ argument in favour of widely available contraceptive vasectomy, yet believing this to be a controversial opinion, Wallace chose to write to Haynes privately rather than through the public forum of the journal as was the traditional method of response – attitudes had not yet progressed to the point where Wallace felt confident publicly identifying himself with the long-term provision of surgical contraception. By 1969, the MJA was considerably more supportive of contraceptive sterilisation, and it was very much the case that this support developed gradually over the course of the 1960s in conjunction with contextually liberal understandings of sexuality and reproduction. By 1971 there was an exponential increase in discussion of and support for contraceptive sterilisation: this continued until the mid-1970s, after which the MJA once again fell silent on this now normalised, uncontroversial topic.

In 1963 the AMA deemed sterilisation to be illegal. Ten years later contraceptive sterilisation had become a readily accessible and normalised aspect of Australian medical practice – yet this transition was not based on any legislative development. The legal history of contraceptive sterilisation in Australia is characterised by obscurity and

ambiguity, however within eugenic histories of sterilisation, significant importance is attributed to legal developments.\textsuperscript{101} This has created the misguided assumption that legalisation is equally important in the narrative of contraceptive sterilisation, when in fact the lawfulness of contraceptive sterilisation has never been officially clarified in Australia: instead these procedures have been governed by legal understandings of assault and consent.\textsuperscript{102} Therefore this legal history has been one of changing public opinion, rather than legislative development. Throughout the twentieth century, Australians regarded Britain and the British Medical Association (BMA) as the authority on the legal status of tubal ligation and vasectomy.\textsuperscript{103} Prior to 1960, the BMA’s position had been that the legality of sterilisation was akin to that of therapeutic abortion, permissible only in life-threatening circumstances.\textsuperscript{104} This was first re-evaluated in 1960 as a direct result of a ‘change in the wind of opinion over recent years’, namely the increasing demand for contraceptive sterilisation in the 1950s.\textsuperscript{105} Once considered criminal assault and thereby illegal, the Medical Defence Union altered its position and declared that: ‘An operation for sterilization is not unlawful whether it is performed on therapeutic or eugenic grounds or for other reasons, provided there is full and valid consent to the operation by the patient concerned.’\textsuperscript{106} In Australian and British law, assault and consent are directly connected and are defined by contemporary social convention: the difference between socially


\textsuperscript{103} Wallace to Haynes, 26 May 1967, Box 5, ‘Medical Journals’, VHWC.

\textsuperscript{104} ‘Legality of Sterilization’, \textit{British Medical Journal} vol. 2, no. 5211 (1960), p. 1510. The Australian Medical Association supported this statement and advised that: ‘Except for therapeutic reasons, no member should perform an operation for sterilization on a male or female. Not only is it ethically wrong to do so, but it is legally wrong, even if consent has been given.’; ‘Sterilization’, \textit{The Medical Journal of Australia} vol. 2, no. 7 (1963), p. 283.

\textsuperscript{105} For a detailed account of the legal history of contraceptive sterilisation in Britain, see Penney Lewis, ‘Legal Change on Contraceptive Sterilisation’, \textit{The Journal of Legal History} vol. 32, no. 3 (2011), pp. 295-317.

acceptable behaviour and grievous bodily harm is ever changing and determined by public opinion.

Whether sterilization satisfies the description of being for a “generally approved social purpose” [i.e. contraception] is, of course, one of those questions the answer to which rests not on any immutable principle but on changing values in the community.107

The distinction lies in what a person can legally consent to, that is, the difference between an assault that occurs during a sporting event, and an assault that leads to serious bodily harm.108

The issue…is whether the patient can validly consent to the operation [sterilisation] for non-therapeutic reasons [i.e. contraception]. If he cannot, the operation is a criminal battery upon him by the surgeon…with intent to do grievous bodily harm; the patient himself may also be held guilty of a misdemeanour. Whether consent can validly be given to a surgical operation is generally said to rest upon public policy.109

Prior to the 1960s and ‘70s, contraceptive sterilisation was not considered socially acceptable, many doctors considered the procedure to be illegal, and feared litigation.110

However as socio-medical attitudes became more accommodating and the public demand for surgical contraception increased, sterilisation transitioned into the realm of socially acceptable and therefore legal practice.111 In 1970, the British Medical Journal wrote that sterilisation was only illegal when it was considered to be ‘plainly injurious to the public

107 Finlay and Sihombing, Family Planning and the Law, p. 97.
109 Glanville Williams, The Sanctity of Life and the Criminal Law, quoted in Finlay and Sihombing, Family Planning and the Law, p. 96.
110 Technically the risk of litigation was higher prior to the 1960s, however no practitioner in Australia or Britain was ever charged with assaulting a patient as a result of performing a vasectomy or tubal ligation procedure. The greater risk came from disgruntled spouses who did not approve of their partners decision to undergo sterilisation; ‘Legality of Sterilization’ [1960], pp. 1510, 1516; ‘Legality of Sterilization’ [1970], pp. 704-5.
interest’, for example when done to facilitate a lifestyle of promiscuity.\textsuperscript{112} Despite having been declared legal in the interests of family planning, uncertainty lingered in Australia into the 1970s, which culminated in a recommendation from the Australian Law Reform Commission that sterilisation be nationally legalised.\textsuperscript{113} Although this never eventuated, the popularity of contraceptive sterilisation triumphed and eradicated any lingering legal confusion – the success of which is most powerfully demonstrated in the Catholic uptake of contraceptive sterilisation practices in the 1960s, ‘70s, and ‘80s.

The Catholic uptake of Contraceptive Sterilisation

The rapid social change of the 1960s and the effects of the “sexual revolution” were manifest in Catholic responses to contraception, both in relation to the intensified papal ban and the widespread lay rejection of this ban. In the second half of the twentieth century the only formalised opposition to contraceptive sterilisation came from the Catholic Church: the more prevalent contraception became, the harder the Church fought to suppress it, seen in the fortification of the papal ban on artificial birth control via the release of \textit{Humanae Vitae} and the corresponding acceleration of the Natural Family Planning (NFP) movement in the 1970s.\textsuperscript{114} However, in the 1960s the lay Catholic

\textsuperscript{112} ‘Legality of Sterilization’ [1970], pp. 704-5.
\textsuperscript{114} In this context artificial birth control refers to any interference with conception during intercourse, i.e. sterilisation, abortion, oral contraceptives, IUDs, condoms, diaphragms or withdrawal. In contrast, Natural Family Planning relies on a symptomatic awareness of ovulation, combined with periodic abstinence during the woman’s fertile period. Previously known as the Rhythm Method, or “Vatican Roulette” because it was highly unreliable until the mid-1970s, accuracy has since greatly improved. In the twenty-first century many secular couples now use it as an environmentally friendly, hormone-free contraceptive alternative to the pill; Laura Eldridge, \textit{In Our Control: The Complete Guide to Contraceptive Choices for Women} (New York: Seven Stories Press, 2010), pp. 205-26; Interview with Nicholas Tonti-Filipini by Tiarne Barratt, 20 June 2014. (The late Professor Tonti-Filipini was Australia’s first hospital ethicist, and was the Associate Dean and Head of Bioethics at the John Paul Institute for Marriage and Family until 2014.) For more on the Australian involvement in Natural Family Planning, see the work of John and Evelyn Billings; Evelyn L. Billings with John J. Billings and Maurice Catarinich eds., \textit{Billings Atlas of the Ovulation Method: The Mucus Patterns of Fertility and Infertility} [fifth edition] (Melbourne: Ovulation Research
community rebelled against official Church teachings and began to think and act in favour of contraception, including sterilisation. The changing understandings of sex, sexuality, gender, marriage, and population that had taken place throughout the 1950s and ‘60s had a revolutionary effect on many members of the Australia laity – these new ideas were now more pervasive than the influence of the papacy. Historians can often overlook the significance of religion and religious belief in social histories, underestimating the strength of the ties that these phenomena have. However religion and reproduction had a significant impact on individuals’ lives, and the full extent of the contraceptive revolution that facilitated the rise of sterilisation is apparent in the increasing Catholic uptake of birth control in this period. Although the reconciliation of religion and contraception was a difficult process for many – a 1973 survey undertaken by the Demography Department of the Australian National University revealed that Catholics were fifty per cent less likely to use artificial contraception than their secular counterparts, and instead favoured NFP.115 By 1980 Catholic and non-Catholic women were using contraceptive sterilisation at virtually the same rate: it was during the rapid social change of the 1960s that this shift in attitudes began to take place – epitomised in the overwhelming rejection of Humanae Vitae, the infamous encyclical released by Pope Paul VI in July 1968.116

The second half of the twentieth century was a time of unprecedented change within the Catholic Church. The Second Vatican Council transformed the relationship between the clergy and the laity, as well as the role of the Church in an increasingly modern world.117 Catholic use of contraception increased as religious decision-making

Centre of Australia, 1989).
began to steer away from a system of hierarchical decree towards one of informed individual conscience: there was a gradual shift in the way that God was perceived, a loving God became more prominent than the figure of authority experienced by earlier generations of Catholics.\textsuperscript{118} Yet although the Church had attempted to modernise, for many, it was a case of too little, too late, and in spite of this newfound religious freedom and questioning – or perhaps because of it – throughout this period there was what amounts to a mass exodus from the Catholic faith.\textsuperscript{119} The Catholic histories of Australia that depict the 1950s as a golden era of domesticity and traditional family values, a high point in religious participation prior to the upheaval of the 1960s, demonstrate that for some, the changes of Vatican II were traumatic and profoundly shook their understanding of the Church and their place in it.\textsuperscript{120} Whereas there were others who rejoiced in this disruption to tradition, questioning Church authority and its position in their lives. This led to eventual disillusionment and a gradual distancing from religious life that continued throughout the twentieth and twenty-first centuries. These polarised memories of the impact of Vatican II reveal that the popular characterisations of fifties conservatism and sixties liberalism permeate understandings of religious and secular history alike – although they are perhaps more accurate in the context of Catholic culture and the scope of clerical authority in the 1950s.\textsuperscript{121}

In a futile attempt to retain authority over the laity, papal condemnation of contraception increased throughout the twentieth century in direct comparison to its

\textsuperscript{119} Paul Collins, \textit{Believers: Does Australian Catholicism Have A Future?} (Sydney: University of New South Wales Press, 2008).
\textsuperscript{121} In 1950s Australia, Church authority was powerful and there was a clear hierarchy in place regarding the clergy and the laity. In his 2011 autobiography, \textit{To Reason Why}, former Catholic priest John Burnheim speaks of Cardinal Gilroy and the authority and obedience that he dictated. ‘Running a tight organisation meant keeping the laity in their place…vigorous and uncensored debate was anathema to Gilroy and those around him. Suppression was their answer.’; John Burnheim, \textit{To Reason Why: From Religion to Philosophy and Beyond} (Sydney: Sydney University Press, 2011), pp. 51-2.
increasing uptake, culminating in *Humanae Vitae* – a provocative response to the 1966 Majority Report of the Papal Birth Control Commission.\(^\text{122}\) The Commission was established by Pope John XXIII in 1963 to investigate the issue of birth control, modernity, and the Catholic Church: its seventy two members met in Rome from 1963-66.\(^\text{123}\) Presented in the form of a majority and a minority report, the results of the commission were divisive. The Majority Report was a rejection of *Casti Connubii*, in which theologians, medical professionals, members of the laity, and senior clergy voted in favour of reforming the encyclical and permitting the use of birth control in circumstances of chaste marriage.\(^\text{124}\) In light of the ‘complexity of modern life’ the commission felt that previously prescribed moral norms could no longer be pushed to the extreme:

> The *regulation of conception* appears necessary for many couples who wish to achieve a responsible, open and reasonable parenthood in today’s circumstances. If they are to observe and cultivate all the essential values of marriage, married people need decent and human means for the regulation of conception.\(^\text{125}\)

Taking into account contextual social changes to marriage, the family, the status of women, population, lowered rates of infant mortality, and new knowledge in the areas of biology, psychology, sexuality and demography, ‘...a long and often heroic abstinence’ was no longer seen as the only viable contraceptive option for Catholics, and the majority

\(^{122}\) From the end of the nineteenth century onwards, encyclicals and official addresses on the subject of birth control become more frequent. The following list is not inclusive, but offers an indication of this phenomenon: *Arcanum*, encyclical of Pope Leo XIII on Christian Marriage, (1880); *Casti Connubii*, encyclical of Pope Pius XI on Christian Marriage, (1930); ‘Address to Midwives on the Nature of their Profession’, by Pope Pius XII, (1951); ‘Address to Congress of Urology’, by Pope Pius XII, (1953); *Mater et Magistra*, encyclical of Pope John XXIII on Christianity and Social Progress, (1961); Papal Birth Control Commission, met in Rome between 1963-6; *Humanae Vitae*, encyclical of Pope Paul VI on the Regulation of Birth, (1968).


of the commission felt that the use of artificial birth control did not fundamentally differ from the use of periodic abstinence. In contrast, the Minority Report expressed a desire to uphold the papal ban on all forms of artificial contraception, from abortion to withdrawal, and received official papal support in the form of *Humanae Vitae* – a watershed moment in Catholic history. In the eyes of the Church, there was no difference between abortion, vasectomy, tubal ligation, and the pill – their ‘very nature contradict[ed] the moral order’.

…all direct abortion, even for therapeutic reasons, are to be absolutely excluded as lawful means of regulating the number of children. Equally to be condemned, as the magisterium of the Church has affirmed on many occasions, is direct sterilization, whether of the man or of the woman, whether permanent or temporary.

*Humanae Vitae* was intended to act as the official last word on these practices, however in reality this discussion was far from over. After the release of the Majority Report in 1966, many people waited in hopeful anticipation for an official statement reaffirming the majority position. What they received was an encyclical conceived to fortify the Church ban on contraception, the shock of which sparked an outcry previously unheard of amongst clergy and laity alike.

An analysis of the response of the (primarily Sydney-based) Australian laity and clergy to the Church ban on contraception has revealed an intriguing phenomenon – that many individuals had a remarkable capacity to disagree with this position, whilst remaining faithful Catholic adherents. While this was not true for everyone, and there were many who either supported this ban or quit the Church entirely as a result, for the

127 *Humanae Vitae*, pp. 14, 1-2, 6, 10, 16.
128 For further information regarding the Australian Catholic laity on sex, marriage and contraception, see Naomi Turner’s oral history collection in which discussion of these subjects occurs organically, demonstrating the centrality of these issues to Catholic life; Turner, *Ways of Belonging*. 
most part it would appear that by the late twentieth century, contraception and Catholicism were no longer mutually exclusive concepts – an effect of changing sexual mores in the 1960s. In this context, priests were often required to balance their dual responsibility to the laity and to the official Church in their response to contraceptive sterilisation: this was a balance that did not always sit comfortably with the clergy, and Sydney man, former priest Roger Pryke (1921-2009) was a unique example of this.

Ordained in 1944, Pryke was an influential member of the Australian clergy for close to three decades, until his split with the Church and subsequent marriage to lay woman, Meg Gilchrist, in 1972. In the 1960s, Pryke had a reputation amongst the priesthood and laity alike for his controversial opinions on contraception. Although Pryke never explicitly gave permission to use birth control – in his own words, ‘I explain to people what I think is the medical and moral position, I refuse to advise’ – Catholic women would nevertheless travel from around Sydney to visit his confessional on the hope that they would be able to discuss the pressures of continuous childbearing with a sympathetic listener.

Oral history participant Deborah Fielding recalls hearing of Pryke and his tolerant views on birth control through the grapevine of her Catholic social network. She evoked the experience of first speaking to a priest who empathised and understood the hardships she faced as a result of five children and a husband unwilling to practice periodic abstinence:

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129 Kaufman, Why You Can Disagree and Remain a Faithful Catholic, pp. 52, 50-102.
130 For further information regarding the life and impact of Roger Pryke see; Francis R. Harvey, Traveller to Freedom: The Roger Pryke Story (Sydney: Freshwater Press, 2011).
He said to me] “God trusts you, trust yourself”. You know, those words were phenomenal! That we actually had the freedom to do what we had – what we thought we had to do, and it wasn’t going to destroy our relationship with God!¹³²

For many years Fielding had been deeply perplexed by the inevitability of her fertility and as a Catholic, her inability to control it. Fielding was born in 1936, raised by a Catholic mother, educated in the Catholic school system, and married at twenty-three: her outlook on life was entirely influenced by her religion, and with no concept of self-determination in matters of family planning, she struggled through eight continuous pregnancies. Her meeting with Roger Pryke in the late 1960s marked the beginning of a new era in her life, characterised by a more egalitarian relationship with God and a rejection of Church authority in her personal life. Fielding felt that her generation – women starting their families in the 1950s – were the last generation of Catholics to be so strongly influenced by the Church position on contraception. By the mid-1960s, she had begun to notice that the younger women of her parish were using contraception and subsequently only had two or three children, compared to the eight or nine common within her circle of friends. This observation empowered Fielding to take control of her own fertility: after a short-lived experience with the pill, Fielding became dissatisfied with the associated side-effects – a common occurrence in the late 1960s – and underwent tubal ligation surgery in the early 1970s. Unlike the younger generations she described, she had been obedient to the point of breaking and the additional children she had as a result of the ban on contraception had a lasting impact on her life and relationship with the Church.¹³³

¹³² Interview with Deborah Fielding*, 23 April 2014.
¹³³ Close to five decades later, remembering the younger women who only had two and three children still stirred up intense emotion in Fielding: “They [the younger generations of Catholics] have a free will and they know they’ve got a free will. Which we didn’t really. We never were given that freedom to think for ourselves, certainly not in school, it was drummed into us”; Interview with Deborah Fielding*, 23 April 2014.
However, attitudes towards contraception were more than generational – the age at which women began their families could be equally influential. For example, oral history participant Elizabeth James, who did not have children until the “sexual revolution” was well underway in 1966. Born in 1933, James shook the influence of Church authority at a younger age than Fielding and did not express the same concerns regarding the coexistence of her religious beliefs and her liberal outlook on contraception. During the 1950s James remained single and worked as a receptionist at an underground abortion clinic on Macquarie Street in Sydney. This immersion in the public culture of sex meant that after the birth of her second child, James felt confident enough to send her husband to have a vasectomy in 1970, threatening a practice of separate beds and enforced abstinence if he refused: in order for a mutually satisfying sexual relationship to continue, she had to be safeguarded from unintended pregnancy and had no desire to undergo tubal ligation when vasectomy was less expensive and comparatively easier.¹³⁴ Both Fielding and James went to Catholic schools in NSW, had committed Catholic mothers and chose either tubal ligation or vasectomy in the early 1970s, yet the circumstances that led to this mutual outcome of contraceptive sterilisation were vastly different. This reveals the extent to which attitudes regarding sex, marriage, and contraception had altered by this point, in addition to the widespread availability of contraceptive sterilisation by the early 1970s, as even the Catholic laity were now in support of this phenomenon: this was partially the result of an increasingly secular society, and partially due to the pervasive and overarching influence of the “sexual revolution” and concerns regarding population growth.

Father Mark Davidson, a priest ordained in 1968 and now in his early eighties, spent the majority of his working life in rural NSW and was one of the few members of the clergy to respond to a call for oral history participants to discuss sterilisation and the Catholic

¹³⁴ Interview with Elizabeth James* by Tiarne Barratt, 24 May 2014.
Church. Davidson was similar to Pryke in his actions: unofficially he rejected *Humanae Vitae* and would offer words of understanding and implicit permission to members of the laity who sought his advice on contraceptive sterilisation. However, Davidson wished to remain anonymous in this study as he continues to be concerned about the potential ramifications if his superiors were to find out that he had encouraged lay use of sterilisation throughout his ministry.\(^\text{135}\) This highlights the ongoing scope of Church authority and the fear that it dictated: although it has been possible for individual Catholics to reject the official ban on contraception, not all who underwent contraceptive sterilisation could shake lingering feelings of guilt and shame. In a recent interview, Daniel Watson, a parish priest from Western Australia ordained in 1965 discussed his experience of sterilisation in Confessional. Though he did not approve of contraception himself, he believed that his biggest role had been in helping people to move on after their operation and accept the decision that they had made – lingering feelings of guilt were common, despite the separation of sex and reproduction that was characteristic of secular society. ‘Sometimes, but not often, people would seek guidance, but mostly it was “post-partum”, in other words, after they (or their partner) had had the operation. In that case it was a matter of accepting the sterilisation and “moving on”.’\(^\text{136}\) Indeed both priests interviewed – Davidson and Watson – expressed that post-operative sterilisation counselling was a frequent occurrence within their ministries. This indicates the difficulties faced by people during their attempt to reconcile contraception with Catholicism, but it also shows that their desire for contraception outweighed their guilt: they only sought counselling after the fact, not wishing to be advised against it.

\(^{135}\) Interview with Father Mark Davidson*, 10 April 2014.

\(^{136}\) Interview with Father Daniel Watson*, written response completed 6 May 2014.
An extreme example of this guilt is Queensland man Jack Swan who felt the need to reverse his vasectomy a little over a year after the operation had taken place. There was some debate amongst Swan’s doctors about the true reason he desired a vasectomy reversal: some accepted his religious guilt as adequate reasoning, while others believed that underlying issues associated with his masculinity and self-perceived lack of sexual virility were the driving cause. Although nowhere in the evidence do we get Swan’s direct thoughts, his patient card supplies that ‘For religious reasons (R/C) Jack Swan would like a reversal…Feels like [he] is now getting psychological trauma because it is against his religion.’ For others, it was not internal guilt that made the contraceptive ban hard to defy, but what their peers would say upon finding out that they had undergone sterilisation. One woman went as far as to ask her priest if the scandal created by her (secular) husband’s vasectomy was reasonable cause for their separation. Another man, fearful of judgement from his Catholic community, arranged for vasectomy doctor Barbara Simcock to perform his sterilisation off the record in the privacy of his own home, in order to ensure that the entire affair was kept secret – the risk of being seen at a vasectomy clinic was more than he was prepared to sacrifice. Although the influence of Church authority continued to feature in these experiences of contraceptive sterilisation, it no longer prevented people from using contraception and the battle to control the private lives of the laity had been lost.

As with any phenomenon, people reacted differently and unpredictably, and in contrast to this Catholic guilt, were those who could not wait to share their experience of contraceptive sterilisation with their parish community. Incidentally, this attitude was a cause of great alarm to one particular priest as he grappled with how to respond to the

137 Vasectomy patient card, Jack Swan*, 1978, BEPC.
139 Interview with Barbara Simcock, 24 July 2013.
popularity of contraceptive sterilisation within his parish in 1960.\textsuperscript{140} Although many of the individual experiences showcased here revealed an internal struggle with the marriage of Catholicism and contraception, it did not prevent them from seeking sterilisation and \textit{Humanae Vitae} does not appear to have impeded actual practices. It would seem that by the time the encyclical was issued, the damage had already been done, the laity had already become disobedient. \textit{Humanae Vitae} is remembered as a watershed moment in Church history and denying its significance would be futile, yet when it was first issued, the individual uptake of contraception was so prevalent that the public outrage it sparked instead related to issues of population growth – how could the Pope continue to support a ban on contraception in the face of global overpopulation?\textsuperscript{141} In many ways, the impact of this document related to public discussion rather than private practice; similar to the way in which discussion of eugenic sterilisation dominated the first half of the twentieth century, while contraceptive embodiments were silently taking place in private practice. Although the Church continued to condemn contraception, members of the laity were undergoing sterilisation operations with the support and acceptance of their priests, or else with a disregard for their disapproval. The factors that had facilitated the rise of contraceptive sterilisation more generally were not lost in the experiences of the Catholic laity, and by the early 1970s the success of these practices had nowhere to go but upward.

\textbf{Conclusion}

The 1960s were a period of rapid social change, during which time sterilisation became a widespread method of contraception with significant public support. In the context of the “sexual revolution”, sex and reproduction became increasingly separated; the women’s liberation movement and the introduction of the pill both increased women’s confidence

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\textsuperscript{141} Robertson, \textit{The Malthusian Moment}, p. 156.
\end{footnotesize}
when it came to engaging with birth control, and their expectations of reliable and effective contraception; rapid population growth and fears of global resource shortages raised the public profile of sterilisation procedures and diminished moral opposition to birth control; the medical community began to support and advocate for greater access to contraceptive sterilisation; and as public opinion became increasingly favourable as a result of these developments, the legal ambiguity of surgical contraception was dispelled, which enabled tubal ligation and vasectomy practices to fulfil their contraceptive potential in the 1970s and ‘80s. More than anything, the extent of the social change that took place regarding attitudes and practices of sterilisation in the 1960s is revealed in the Catholic uptake of surgical contraception: the group who represented the only formalised opposition to this phenomenon were now, albeit unofficially, in support of it, demonstrated in the papacy’s ongoing attempts to put a stop to the laity’s use of birth control. In many ways, the crucial changes to attitudes towards gender, sexuality, reproduction, sex, population, and contraception that facilitated the rising popularity of surgical contraception in the 1960s, had roots in the 1950s. For example, it was during the 1950s that the importance of mutual sexual satisfaction was first emphasised and demanded within social norms, and it was in this context that international family planning programs began to emerge in light of the imminent “population bomb”. Although contraceptive sterilisation did not become readily available until the 1970s, this success would not have been possible without the earlier context of the 1950s and ‘60s: this underscores the importance of decentralising the chronology of the pill, and considering the history of birth control in relation to the twentieth century as a whole.

While these broader developments of the 1950s and ‘60s were taking place, the final three doctors of this study – Bruce Errey, Barbara Simock and Ian Stewart – were undergoing their medical training, on the path to becoming some of Australia’s leading
providers of contraceptive sterilisation in the 1970s and ‘80s. Although there were no legal changes to the contraceptive status of vasectomy and tubal ligation, the impact of the 1950s and ‘60s meant that these doctors were able to begin practicing surgical contraception in the early 1970s without the social backlash experienced by earlier generations.\(^{142}\) This commitment from a new generation of medical professionals meant that access to contraceptive tubal ligation and vasectomy increased considerably in the 1970s, as they went on to train other doctors and to continue to publicise their work. In addition, the popularity of the pill came into question in the late 1960s and was the subject of considerable media attention and scandal due to related side effects, namely blood clots and its long-term viability.\(^{143}\)

As they sleep, the powerful hormones in the pill will enter the blood stream and spread throughout the body, producing changes in nearly every organ and body function. Never in history have so many individuals confidently consumed such a powerful medication with so little information as to the potential hazards and alternatives… Recent studies have brought to an end ten years of wishful thinking regarding the safety of the pill.\(^{144}\)

While this alone does not account for the significant increase in demand for contraceptive sterilisation in the 1970s, it did raise issues about the need for long-term reliable contraception for women who had completed their families, but still had many fertile years ahead of them. People who had been using the pill throughout the 1960s were now faced with the question of ongoing contraception: in this context, the pill had the potential for

\(^{142}\) For example Wallace’s reluctance to publicly associate himself with the contraceptive vasectomy, or the public anger experienced by Siedlecky when she went into private practice in the 1950s and began offering surgical contraception – she recalled occasions where her surgery was vandalised or her car keys stolen etc; Interview with Stefania Siedlecky, 2 September.


complications and side effects when used by older women. For those who sought permanent contraception rather than pregnancy spacing, tubal ligation and vasectomy had become increasingly realistic and appealing options, and by the 1970s there was a veritable explosion in the contraceptive popularity of sterilisation. Using oral history interviews with patients of tubal ligation and vasectomy, chapter four analyses experiences of sterilisation during the height of its contraceptive popularity and the effect that this popularity had on individual lives and the Australian contraceptive landscape.
Chapter Four: The Contraceptive Popularity of Sterilisation, 1970-1986

Introduction

Having reached the end of his career, Victor Hugo Wallace set out to pen a final manuscript in 1976, an account of the history of birth control in Australia and of his place within that narrative. The contraceptive landscape had been drastically transformed since the early days of Wallace’s practice, and this excited rather than daunted him: he was eager to reflect upon these changes as he marvelled at the difference that time could make.

I wish to compare and contrast the extensive and remarkable changes which have taken place in recent years in the public and governmental attitudes to family planning, and that includes surgical sterilisation as a means of contraception for man or woman… The change in public attitude towards family planning in the period between 1939 and 1976 is quite surprising. In the climate of opinion which prevails today is it very difficult to understand the moral indignation expressed in 1939, when Archbishop Mannix, Sir John Harris, the Minister for Health, and many others expressed their determined opposition to the establishment of birth control clinics. There has also been a dramatic change in the attitude to abortion and vasectomy operations…¹

In 1976, the contraceptive application of sterilisation was widespread, a phenomenon that Wallace attributed to dissatisfaction with the pill in a context where couples increasingly expected reliable contraception:

An increasing number of married couples desire permanent protection against the possibility of pregnancy. Their life style is satisfactory to them and they do not want any more children. Furthermore, they wish to avoid the possible undesirable side effects of oral contraceptives. The constant remembering to take the pill may become irksome. For the man the number of contraceptive methods is, at present, very limited. He may wish to avoid throwing

responsibility for contraception on to his wife and so surgical sterilisation is considered.\(^2\)

As he wrote these words, the social status of vasectomy had altered unimaginably since the 1930s as the once private world of sterilisation had finally become public. This transition inspired Wallace to put forth his personal history of vasectomy and to move his experiences beyond the closed doors of the operating theatre and into the public eye. Although this manuscript never progressed past its first draft as Wallace died during the writing process in 1977, it nevertheless represents a unique snapshot in time and the only direct account of Wallace’s role in the rise of contraceptive sterilisation in Australia. The commencement of this manuscript reflects the pace at which attitudes towards sterilisation were transformed in the 1970s as public demand overshadowed previous controversy: in 1973 Wallace publicly acknowledged his vasectomy work in the *Medical Journal of Australia* (MJA) for the first time, while only three years later, he had devoted a book to it.\(^3\) This was possible because the 1970s and ‘80s witnessed an explosion in the contraceptive popularity of sterilisation in regards to the global uptake of vasectomy and laparoscopic tubal ligation.\(^4\) It was also a point when medical practitioners joined historians in writing about birth control and Wallace’s manuscript fits into this literary trend.\(^5\) In Australia, sterilisation operations that had once been difficult to access became readily available; legal ambiguity was dispelled and doctors no longer feared prosecution; contraceptive sterilisation – a phenomenon which had once been covert and intensely private – became a media sensation, a hot topic of discussion, whether it be in regards to population politics, women’s liberation activism, new developments in medical technology, or the impact it had on individuals’ reproductive lives and freedoms. By the

\(^2\) Wallace, ‘The Development of Family Planning in Australia’, p. 80, Box 35, VHWC.


\(^4\) See Figure 4.1, ‘Contraceptive Sterilisation Operations processed through Medibank per year, 1973-8’.

mid-1970s contraceptive sterilisation could be openly discussed with family, friends and colleagues: by the mid-1980s it was available more or less on demand, its patients unable to understand how tubal ligation and vasectomy had previously been shrouded in secrecy and confusion. It was this widespread success that prompted Wallace to embark on a history of family planning in Australia, and it was this period of popularity that inspired my thesis: four decades apart and from entirely different circumstances, we both queried – how did this phenomenon come about?

Influenced by everything from the rise of an international eugenics movement, to the “sexual revolution” and the uptake of the pill, contraceptive sterilisation became steadily more popular throughout the twentieth century, until this success plateaued in the mid-1980s with rates of sterilisation in Australia at an all-time high. In 1986 the Australian Family Project surveyed married women aged 20-49 and found that 27.7% of women were protected from pregnancy by tubal ligation and 10.4% were protected by vasectomy. Overall, 38.1% of women surveyed were using male or female sterilisation, compared to 24% of women in this study who recorded using the pill for their contraceptive needs.6

Until the early-1970s, the uptake of tubal ligation and vasectomy had been gradual and this newfound popularity was the product of the unique social context of the 1970s and ‘80s. When it comes to thinking in decades, “the seventies” and “eighties” have not been subject to the same academic historicising as “the fifties” and “sixties”. It is often considered that the 1970s are overshadowed by “the sixties”, less radical in contrast and frequently characterised by the Vietnam War instead of sexual liberation.7 Similarly, the 1980s must


7 Beth Baily and David Farber eds., America in the Seventies (Kansas: University of Kansas Press, 2004), p. 1; Bruce J. Schulman, The Seventies: The Great Shift in American Culture, Society and Politics (New York:
contend with the idea of “the eighties” as a frivolous decade characterised by pop culture, although this stereotype is beginning to be overturned. In the 1970s, the developments of the 1960s were manifested in public policy; the Whitlam government implemented significant advances in healthcare, university tuition fees were abolished; with the uptake of the women’s liberation movement came the real impact of second wave feminism; the impact of the gay liberation movement and the global population control movement equally characterised this decade. The 1980s witnessed the beginnings of the international AIDS epidemic, the fall of the USSR, the introduction of modern technology – mobile phones, computers, the internet; stock markets around the world crashed in 1987 on Black Monday, and the beginnings of the feminist backlash emerged, when only years earlier women’s liberation was an international force to be reckoned with. The broader context of this era contributed to socio-medical perceptions of contraceptive sterilisation in the same way that previous decades had done so, the difference being that in the 1970s, the public was now ready to embrace this phenomenon.


The 1970s and ‘80s were a period of significant achievement for Australian women and the gains of the women’s liberation movement were extensive. The introduction of the pill transformed expectations in terms of access to and the reliability of birth control; the bar that forced female public servants to relinquish employment upon marriage was removed; there was a move towards equal pay, no-fault divorce, benefits for single mothers, paid maternity leave and increased childcare; the first steps towards the decriminalisation of abortion were taken; and anti-discrimination laws were introduced with the 1986 Affirmative Action Act designed to create equal employment opportunities for women – developments that occurred as a result of the impact of second-wave feminism in this era. Women had been on the trajectory of increasing participation in paid employment for several decades, and this was materialised in the 1980s. The discriminatory practices that had catered to the male “breadwinner” were slowly being challenged in favour of workplace equality, and the rise of part-time work enabled more

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**Figure 4.1**: Data compiled by Dr Barbara Simcock and Dr Bruce Errey based on number of contraceptive sterilisation operations processed through Medibank in 1973-8, located in Bruce Errey Private Collection and accessed January 2014.

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women to enter paid employment – although part-time work ultimately reflected gendered inequality in the workforce.\textsuperscript{11} There was a move away from motherhood as the defining feature of womanhood, a rejection of women’s lives revolving around the home, and an increased public demand for tubal ligation. Young women in their early twenties were the group most likely to be involved in the public activism associated with the women’s liberation movement, and this too was reflected in the public demand for tubal ligation in the 1970s.\textsuperscript{12} While most women sought sterilisation to limit the size of their families, these women sought sterilisation as a matter of principle:

\textbf{Stefania Siedlecky:} Now there was a time – I think when they called it the second wave of feminism \textit{laughter} some of those earlier feminists were a bit of a nut – and I had these people, 18, 19, 20, coming along and wanting to be sterilised. And I said, “You haven’t even had a chance to have a pregnancy yet, you have to wait a while”. They had to calm down and wait a while, because to have a sterilisation reversed, I mean you can have it reversed, but it’s not the safest thing to do. So I had to sort of get them to take on some other sort of contraceptive in the meantime. But there was a time when they all came along and said they didn’t want to have a pregnancy, they wanted to have a sterilisation.\textsuperscript{13}

Based on her work in women’s health activism in the 1970s, Siedlecky would appear to have been an avid participant in the Sydney women’s liberation movement. However Siedlecky viewed herself outside of this trend and the radicalism of the generation she described here. The young women of Siedlecky’s memories may or may not have been successful in their initial demands for sterilisation, yet irrespective of their initial success, they were part of the generation of women who pushed tubal ligation to the peak of its popularity in the 1980s. Whether they proceeded with the operation as a nulliparous

\textsuperscript{13} Interview with Dr Stefania Siedlecky by Tiarne Barratt, 2 September 2013.
woman of twenty, or a parous woman of thirty, their actions reflected a generation of
generations who were aware of their reproductive rights, who publicly expressed these rights,
and who would not be confined to the private sphere. As the social status of women was
transformed, rates of tubal ligation and vasectomy rose in accordance and the
contraceptive landscape was equally transformed – even if this history of sterilisation is
often overlooked in favour of the eugenics movement, the introduction of the pill, and
ongoing abortion struggles.

Since Wallace’s attempt in the 1970s, the history of contraceptive sterilisation in
the second half of the twentieth century has received little attention – scholarly or
otherwise – and in comparison to other methods of contraception, there is a stark absence
of historical analysis. 14 As a trend, sterilisation is difficult to pin down as key dates,
figures, and statistics often elude, unlike the history of the pill for example, which has now
been popularised and made readily accessible through a linear narrative based on a definite
date of introduction and easily situated key actors such as Margaret Sanger. 15 In contrast,
much of the history of contraceptive sterilisation is available now only through the oral
histories of people who experienced this phenomenon first hand in the 1970s and ‘80s. The
doctors of this narrative have already been introduced and their memories will continue to
inform this history, however it is the anonymous patients of sterilisation that take focus
here. In 1979, it was estimated that approximately 75,000 Australians had been voluntary

14 Siedlecky and Wyndham provide one of the few accounts of this history in Australia; Stefania Siedlecky
and Diana Wyndham, Populate and Perish: Australian Women’s Fight for Birth Control (Sydney: Allen and
Unwin, 1990), pp. 46-50; Jesse Olszynko-Gryn, ‘Laparoscopy as a Technology of Population Control: A
Use-Centered History of Surgical Sterilisation’, in Heinrich Hartmann and Corinna R. Unger eds., World of
Populations: Transnational Perspectives on Demography in the Twentieth Century (New York: Berghahn
15 David M.C. Hislop, The People Who Made The Pill: An In-Depth Look at the Characters Behind Oral
Contraception (South Carolina: Advantage, 2011); Elaine Tyler May, America and the Pill: A History of
Promise, Peril and Liberation (New York: Basic Books, 2010). However these straightforward, linear
narratives that are guided by key dates and figures were only made possible by the work of people such as
Elizabeth Watkins and her ground breaking social history of the pill; Elizabeth Siegal Watkins, On The Pill:
Press, 1997).
sterilised that year. Who were these people? The thousands upon thousands of people that chose either tubal ligation or vasectomy: their decisions are often viewed only as they relate to overarching trends and statistics, always as part of the phenomena as a whole. More so than previous chapters, this is an exploration of individual experiences of tubal ligation and vasectomy during the peak of these procedures’ contraceptive popularity. Through patient records, doctor’s personal archives, letters to newspapers and magazines, letters of consent, and a series of interviews that took place in 2013-14, this chapter reveals personal experiences of contraceptive sterilisation and the impact that its popularity had on the lives of everyday Australians.

‘Vasectomania’ in the 1970s

The 1970s were a unique decade for contraceptive vasectomy: never before had public opinion been in such favour of the operation, and never since has it been the subject of such media attention. The social, medical and legal change witnessed in this era transformed perceptions of male sterilisation and the public demand for vasectomy increased exponentially throughout Australia. The stigma of castration lessened, more doctors began performing the procedure or offering referrals, the Australian Association for Voluntary Sterilisation (AAVS) was founded by a group of Australian vasectomists, and based on Medibank claims, it was estimated that from 1973-8, over 120,000 vasectomies were performed. In 1974, Australian authors David and Helen Wolfers – a married couple, one a doctor and the other a psychologist – published Vasectomy and Vasectomania to detail the international vasectomy “craze” that had emerged post-1971: “Vasectomania” is the word we have coined to describe those surges of enthusiasm for

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17 See Figure 4.1, data compiled by Dr Barbara Simcock and Dr Bruce Errey based on the number of contraceptive sterilisation operations processed through Medibank in 1973-8, located in Bruce Errey Private Collection [hereafter BEPC], accessed January 2014; Interview with Dr Bruce Errey by Tiarne Barratt, 15 January 2014; Interview with Dr Barbara Simcock by Tiarne Barratt, 24 July 2013.
this operation which have swept through sections of society repeatedly in the twentieth century. One of these attacks of frenzy is building towards a crest now, in the 1970s.18 As this chapter shows through an analysis of patient case studies, the transformation of vasectomy practices in the 1970s is most evident when patient experiences from 1969-70 are compared with experiences from 1971 onwards.19 The difference is stark and demonstrates the impact that readily accessible surgical contraception had on individuals’ lives, both reproductive and otherwise. An air of desperation characterised patient experiences in 1969-70, which was then replaced by an overall sense of satisfaction with vasectomy from the early 1970s onwards: during 1969-71 vasectomy went from being on the brink of contraceptive success, to achieving widespread global acceptance. After reaching new heights of popularity in the 1970s, rates of vasectomy in Australia have been relatively stable since 1986, unlike tubal ligation, which has been on the decline since the early-1990s.20

The “sexual revolution” had been underway for several years in 1969-70 and the rise of oral contraceptives in the 1960s meant that access to effective birth control was increasingly becoming an expectation, however the contraceptive practicalities of separating sex and reproduction had yet to be fully realised.21 When it became apparent that the pill was not conducive to long-term use, and its side effects became the subject of international media scrutiny in the late 1960s, people turned expectantly to sterilisation,

18 David and Helen Wolfers, Vasectomy and Vasectomania: The History, Surgery and Psychology of the Latest Contraception for Men (St. Albans: Mayflower, 1974), p. 9; The other surges of popularity Wolfers’ refer to here are vasectomy in the context of eugenics and rejuvenation.
19 Case studies refer to vasectomy patient medical records and accompanying letters found in the Victor Hugo Wallace Archive and the Bruce Errey private archival collection, in addition to oral history participants for this project; ‘The Normalisation of Contraceptive Sterilisation in post-war Australia’, Project No. 2013/534, approved by The University of Sydney Human Research Ethics Committee, 4 July 2013.
21 Interview with Wendy Simmons*, written response to ‘Experiences of Tubal Ligation and Vasectomy in Australia’, 8 August 2013; Interview with Jessica Henson* by Tiarne Barratt, 14 January 2014.
only to discover its limited contraceptive availability.\textsuperscript{22} Thus many couples struggled with the contradictory expectations of a mutually satisfying sexual relationship and realistic access to long-term, permanent contraception. By the early 1970s this had culminated in the widespread availability of tubal ligation and vasectomy, yet prior to this had left many Australian couples feeling trapped by their fertility in spite of the availability of the pill.\textsuperscript{23} In October 1970, Bruce Errey received a letter from the wife of a future vasectomy patient, the sentiment of which epitomised the difficulties faced by couples in search of surgical contraception on the eve of its widespread popularity:

Dear Dr Errey,

You have been recommended to us from the Humanist Society. My husband would like to have the vasectomy (male sterilisation) operation. We have tried quite a few Doctors, but they would not do it unless one of us had something wrong with us. We have been trying for over three years to have the operation done. We have talked it over very carefully, if the children or myself are killed in a car smash, or if one of the children gets sick and dies, we are willing to take the risk. My nerves are in a terrible state, my Doctor has me on serenace tablets [anxiety medication] and it is now starting to affect my speech, the problem is starting to affect our marriage. Would you be able to help us? We are both quite willing to sign any papers, my husband starts his holidays on the 11\textsuperscript{th} December [1970]. If you can help us, would my husband have to go into hospital? And if not, how long would we have to stay in Brisbane [the couple lived in Toowoomba, approx. two hours’ drive from Brisbane]? And could you please tell me how much you charge?

Hoping you can help us, yours sincerely, Mr and Mrs Stevenson.\textsuperscript{24}

\textsuperscript{22} Petah Digby, ‘A Vasectomy Clinic: Observational Study’, paper presented at the Australian Anthropological Society Annual Conference, Sydney University, August 1978, p. 3, BEPC; In 1978 Digby found that couples using contraceptive sterilisation were more likely to have relied on the pill for contraception at some point in their relationship: she found that after the convenience of the pill, users were unlikely to want anything more complicated, inconvenient, or uncomfortable, such as IUDs or barrier methods.


\textsuperscript{24} Letter from Mr and Mrs Stevenson\textsuperscript{*} to Bruce Errey, 24 October 1970, BEPC.
The Stevensons’ dilemma was one faced by many couples – how to reconcile a mutually satisfactory sexual relationship and the anxiety of unwanted pregnancy? The issue had begun to affect not only their marriage, but their lives, so they turned to vasectomy: they were not alone in their difficulty accessing the procedure, as in 1970 relatively few doctors were willing to perform vasectomies, let alone affordable vasectomies. Although by the late 1970s many doctors had been forced to modernise in an attempt to remain competitive and retain their clientele, in this context doctors were able to refuse sterilisation requests and referrals without consequence.\(^{25}\)

It is over a year since I had the operation technically known as “vasectomy”, or in popular terminology, sterilization. My only regret since having the operation is that I was unable to obtain it sooner… Making the decision to be sterilized is the least part of the problem; finding a doctor who will perform the operation is another matter. Locally I found medical opinion quite sympathetic to the principle that it would be a fair thing to divorce the pleasures of sexual intercourse from the possibility of procreation; the principle is one thing – the practice is another. Sterilization is potentially a controversial issue and doctors by and large seem petrified of “getting involved”.\(^{26}\)

This Melbourne based patient had the same issues as the Stevensons’ did located in an isolated area of Queensland (QLD) – a state known for its conservative attitudes towards contraception and abortion.

In Queensland vasectomy is not illegal yet most doctors we (my husband and myself) have spoken to are entirely against this form of family planning, and we find this very hard to agree with. Both my husband and myself would like him now to be able to have a vasectomy but he can’t find anyone willing to perform the operation. We have now had 2 children which is all we want and I

\(^{25}\) Digby, ‘A Vasectomy Clinic’, pp. 1-3, BEPC.
\(^{26}\) ‘A Patient’s View of Sterilization’, *The Australian Humanist* no. 15 (September 1970), p. 24, BEPC.
have tried both the pill (before the first baby) and an IUD (before my second child) neither worked.\textsuperscript{27}

This woman was interviewed after the birth of her second child in 1970, where she was faced with the prospect of seemingly endless fertility after unsuccessful experiences with the pill, the IUD, and vasectomy. These individuals had no way of knowing that twelve months later, access to contraceptive sterilisation would be transformed, thus an undertone of desperation characterised their statements and distinctly separated them from vasectomy patients of the mid-1970s.

The unmet demand for contraceptive sterilisation in 1969-70 meant that patients frequently had to travel interstate and for long distances to consult sympathetic doctors. For example, Brisbane local, Greg Hanson travelled to Sydney in 1969 to see a private surgeon and to undergo vasectomy at forty-one years of age: his local doctor had been unable to find a practitioner located in QLD who was willing to operate and his need for the procedure outweighed the cost of travel.

We already had five children, three natural, two adopted, and we were about to be posted to Indonesia… We had no wish to have any children in the medical environment that existed there in those days and in any event, we figured that five was enough but decided to be sure that we didn’t “slip up”!\textsuperscript{28}

However interstate travel was the least demanding aspect of Hanson’s vasectomy experience. Although it is not possible to confirm, all evidence suggests that Hanson’s vasectomy was performed by the inner city “butcher” who demonstrated a covert vasectomy procedure for Barbara Simcock in 1971 at one of Sydney’s private hospitals.\textsuperscript{29}

\textsuperscript{27} Respondent No. 20, July 1979, in Eena M. Job, ‘Knowledge of, Attitudes to, and Practice of Birth Control among 322 Maternity Patients in Brisbane’, unpublished Honours thesis, Department of Anthropology-Sociology, University of Queensland, 1971, p. 6, Appendix D.
\textsuperscript{28} Interview with Greg Hanson*, written response to ‘Experiences of Tubal Ligation and Vasectomy in Australia’, 21 January 2014.
\textsuperscript{29} For further details of Simcock’s recollections of this experience, see chapter one, ‘The Surgical History of Vasectomy’.
In 2014, Hanson recalled that the post-op recovery was painful and lengthy – several weeks – that his vasectomy was ‘somewhat expensive’, and that it required general anaesthetic and an overnight stay in a private hospital. These circumstances match the surgeon and vasectomy technique described by Simcock – an operating technique so unnecessarily violent that she remained appalled by the memory four decades later.\(^30\) It is unlikely that a painful, invasive and expensive procedure, complete with entrenched associations of castration would have become an international contraceptive success, and Hanson later discovered that his vasectomy experience was more demanding than most – although he remained happy with his decision. ‘Overall, we were happy to be free of contraceptives (my wife was on “the pill”) and the worry of any slip-ups. There haven’t been any health consequences for me so I was glad to have had some short term pain for long term gain.’\(^31\) Because Hanson sought vasectomy on the eve of its contraceptive success, his need for reliable contraception was exploited: in much the same way that abortion became safer after it was decriminalised, vasectomy doctors were made more accountable for their actions once the procedure became less covert.\(^32\) Jason Crawly, a man of thirty-seven, similarly travelled a great distance in order to obtain a vasectomy, yet fortunately for him he was referred to Victor Hugo Wallace. Crawly and his wife lived in Rockhampton, an isolated town located more than 2000 kilometres from Wallace’s Melbourne based practice, and made the journey after being advised by Mrs Crawly’s gynaecologist that a sixth pregnancy would be extremely dangerous for her, both physically and mentally:

We do not wish to have any more children because our gynaecologist of Rockhampton has advised that another pregnancy would be very harmful to

\(^{30}\) Interview with Barbara Simcock, 24 July 2013.
\(^{31}\) Interview with Greg Hanson*, 21 January 2014.
the physical and mental health of my wife due to her age, 40 years. He feared that another pregnancy would cause a serious attack of postnatal depression which she experienced after her fifth baby was born by caesarean. He further advised that if I had the vasectomy performed on me, my wife would be free of the worry and the risks involved with conventional contraceptives.\textsuperscript{33}

Feeling that they had no other option – Mrs Crawly could not use ‘conventional contraceptives’ – Jason Crawly travelled to Melbourne in March 1970 where Wallace sterilised him for a fee of $100.\textsuperscript{34} These patients’ willingness to travel and endure significant pain summarises the status of contraceptive sterilisation in 1969-70: it was highly sought after but difficult to access, still covert and controversial, yet fast on its way to becoming immensely popular. A month after Crawly’s operation, Bruce Errey would perform his first vasectomy, which marked the beginning of a flourishing career in male sterilisation and the transformation of the contraceptive landscape in QLD.\textsuperscript{35}

By 1971, vasectomy was no longer pursued with the same sense of urgency that was expressed by earlier patients. Although the pressures of unencumbered fertility remained intact, they were no longer exacerbated by the difficulties previously associated with restricted access to contraceptive sterilisation, and this was largely due to the pioneering work of doctors such as Bruce Errey and Barbara Simcock.\textsuperscript{36} With a total of 30,040 operations performed over four decades (1970-2007), Errey was one of Australia’s most prolific vasectomists.\textsuperscript{37} He estimated that in 1972, he performed approximately eighty-five per cent of the vasectomy operations that occurred in QLD, and within six...
months of his first procedure, men from around the state had begun to seek out his services:

**Tiarne Barratt**: So was it generally word of mouth after a few years, the way people started coming to you?

**Bruce Errey**: My cards always record the source and I would say that it was quickly 98% came on a personal recommendation from somebody who’d heard that they’d been happy with their vasectomy and those couples of the pathetic, almost cadging letters from early ’69 and the early ’70s petered out as there was a lot of publicity in the *Courier Mail, Sunday Mail, Women’s Weekly*, Haden Sergeant [a radio presenter], *National Times* had several extremely good articles about vasectomy, and it publicised itself…

As doctors began to meet the increasing public demand for contraceptive sterilisation, rates of use began to rise in correspondence with ease of access and positive media attention – the popularity of vasectomy continued to grow. The editors of the *MJA* soon stated that ‘Vasectomy as a means of sterilization is not new, but it has rather suddenly become very topical… [and] the question of voluntary sterilization on eugenic grounds has been overtaken by the rapid growth in popularity and acceptance of sterilization for purely contraceptive reasons.’ Indeed the increased media attention that vasectomy received in light of its newfound social acceptability as a contraceptive method acted as a source of information for many patients, which was apparent to a receptionist at Errey’s vasectomy clinic:

…Others have read about it in magazines, or seen something on T.V. They beat about the bush I think because they don’t hear it talked about. Vasectomy

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38 Lecture given by Bruce Errey, *Sixth World Medical and Legal Conference*, Ghent Belgium, 22 August 1982, BEPC.
39 Interview with Bruce Errey, 15 January 2014.
40 See Figures 4.1 and 4.2.
is a new word to them. They have the idea but when it comes to putting it into words they cannot find the language.\textsuperscript{42}

Julian Abbott’s experience of vasectomy in 1973 fit this brief, as although he was comfortable with undergoing the operation, talking about it was an entirely different matter. At thirty-one years of age, Abbott and his wife came to the decision that their two children represented a completed family and vasectomy was chosen as the simpler alternative to tubal ligation – as a man of traditional values, Abbott wished to spare his wife the equivalent operation. Highly uncomfortable with the subject, Abbott abstained from discussing the procedure with friends, colleagues or family members. He knew of no one else beside himself who had personally experienced vasectomy and his knowledge of the procedure came only from the media and later his doctor.\textsuperscript{43} While this would have likely presented an issue of access earlier in the twentieth century, in 1973 Abbott benefitted from the widespread popularity of contraceptive sterilisation as he was able to acquire a vasectomy with minimal inconvenience.

\textsuperscript{42} Interview with receptionist at Bruce Errey vasectomy clinic in the 1970s by Petah Digby, cited in Digby, ‘A Vasectomy Clinic’, p. 13, BEPC.

\textsuperscript{43} Interview with Julian Abbott*, written response to ‘Experiences of Tubal Ligation and Vasectomy in Australia’, 29 November 2013.
Figure 4.2: Graph by Bruce Errey charting the influence of local media on the number of vasectomies he performed from 1970-72, in Bruce Errey Private Collection, accessed January 2014.

The purpose of this graph was to emphasise the correlation between the media presence of vasectomy and the number of vasectomies Errey performed: positive and sensationalised media led to higher numbers, while adverse publicity and lack of publicity accounted for drops in numbers.
Prior to her career as a vasectomist, Barbara Simcock had worked as a doctor at Family Planning NSW, providing clients with all manner of contraceptives. Towards the end of the 1960s, Simcock noticed that requests for vasectomy referrals had started to gradually increase: once a rare occurrence, vasectomy requests began to occur monthly, and then weekly, until in 1971 the President of Family Planning felt that the public demand had become sufficient to warrant a specialised, in-house vasectomy clinic – Simcock would run the operation once she had received adequate training. In February 1972, Simcock travelled to India to learn from the doctors who had given vasectomy an international reputation as an effective method of family planning:

**Barbara Simcock**: I used to go to a hospital down there in Bombay, and it was a special hospital only for Family Planning, and it was called The Family Planning Hospital. People would go there to have their tubes done on a daily basis, all very poor people, but they were so cheerful – I was always struck by the cheerfulness of Indians. As for the vasectomy, they said: “You want to learn vasectomy? Sure! You’ll go out with our team.”

And the team consisted of the doctor, the nurse, and two untrained – I called them hookers: their function was to get out onto the crowded road and snatch out suitable people. So they wouldn’t pick up an old man, nor a young boy, they’d pick up middle aged men or men that they thought were right, and bring them in for a short interview with the nurse man, and if he thought he was a suitable candidate, then they’d get the doctor. All in a bus, a lovely big bus.

And apparently five children was the limit – you could not have a vasectomy unless you’d had five children. Of course most of them had ten, eleven, twelve – so if they said they only had four children, they’d be sent on their way, like throwing a little fish back into the sea. And again you had to ask how many sons they had. So if they had for instance, four daughters and one son, that wasn’t good enough – throw them back out into the sea.

And we’d park outside railway stations, Gateway of India, down by the harbour, but the railway station and the main bazaar was popular, and that was
where you’d find people. And we did roughly seven to eight men per day, and I was there for two weeks. So I got to see a lot, do a lot, learn a lot – gain confidence…

**Tiarne Barratt:** So how did you go about starting the Family Planning vasectomy clinic?

**BS:** Ok, so as soon as I got back from India, Mrs Wilhem [President of the FPA] set it all up. She said “tell me what you need and we’ll start a clinic”. Which we did, and within two to three months we were off, so by about April/May that year, 1972, we were doing them.44

Her experience was unique in the history of contraceptive sterilisation in Australia – Simcock knew of no other doctor who received their vasectomy training in this manner. However, Family Planning NSW had a long history of looking to India for contraceptive guidance beginning in the organisation’s days as the Racial Hygiene Association: ‘we work along the lines of the best of similar clinics, in England, America and India, and are in contact by correspondence, and by journals sent to us, with the work that is being done by those older countries, which pioneered up to date methods.’45 Indian family planning has been the subject of extensive historical analysis.46 India was the first country to incorporate sterilisation into an organised family planning program and played a crucial role in the dissemination of vasectomy throughout the world in the second half of the twentieth century.47 Much of the media attention that vasectomy received in Australia was

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44 Interview with Barbara Simcock, 24 July 2013.
associated with international concern about overpopulation and the popularity of contraceptive sterilisation in India: a desire to participate in the Zero Population Growth (ZPG) movement inspired many couples to choose vasectomy, indeed both doctors and patients of vasectomy were more likely to have an interest in population than those involved with tubal ligation.48

We had had two children; my wife more strongly than I was influenced by ZPG and felt it was wrong to have more children. Since that was definite, sterilization would do away with long term pill taking.49

Shortly after the conclusion of Simcock’s training and her introduction of this technique to Australia, the rising rates of vasectomy in India culminated in what is known as the Emergency Period that took place from 1975 to 1977. The result of a policy ‘more intense and aggressive than any prior or contemporary birth control program, in India or elsewhere’, the Emergency Period was characterised by large-scale coercive vasectomy and the eventual rejection of male sterilisation in India from 1978 onwards.50 Although the Australian uptake of vasectomy had been influenced by Indian sterilisation practices, post-Emergency attitudes were not reflected in Australia: writing in 1976-7, Wallace pointed to the importance of population control with no reference to the Emergency, and for the most part, men continued to happily undergo vasectomy.51

49 Interview with Julian Abbott*, 29 November 2013.
51 Wallace, ‘The Development of Family Planning in Australia’, p. 1, Box 35, VHWC.
Figure 4.3. ‘Trouble Parking?’ sticker displayed in Bruce Errey’s Queensland vasectomy clinic throughout the 1970s.

The majority of vasectomy experiences in the 1970s and ‘80s were marked by simplicity and straightforwardness, by ease of access, and by satisfaction with both the end result and the procedure itself. Although fears of castration and potentially jeopardised masculinity lingered, for the most part these fears were easily expelled. In 1975, Errey received a letter from a recent patient thanking him for his vasectomy:

Your records will show that on August 26, 1975 you performed a vasectomy operation on me. I am now writing to inform you that my wife and I are sorry we did not have this simple operation carried out years ago in view of the complete freedom we now enjoy. You are at liberty to use this letter in any way you think fit.

The invitation for Errey to use this letter in any way he saw fit was an indirect acknowledgement of the lingering fear often associated with vasectomy, a fear that had presumably delayed the patient’s own operation: it was a common belief in the 1970s that reassurance from a man who had already undergone the procedure and come away unharmed was the most effective way to dispel vasectomy anxiety and this man wished to contribute to that trend. In addition, this letter indicates the patient’s satisfaction with his

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52 Vasectomy was ill advised in circumstances where the patient remained in any way uncomfortable with the idea of the procedure, as postoperative regret usually surfaced in those men who had not desired to undergo sterilisation in the first place.
53 Letter from vasectomy patient to Bruce Errey, 25 August 1976, BEPC.
vasectomy and the positive impact that the surgery had on his life and relationship with his wife. In 1985, Jacqui and Daniel King had a similarly satisfying experience, which again required the patient to successfully overcome the irrational fear of castration that remained associated with vasectomy. The parents of two young children, the Kings came to the decision that their family was complete and sought a vasectomy referral from their family doctor. Jacqui – the respondent – recalled that their experience of contraceptive sterilisation was relatively simple, a readily available and realistic method of birth control that was covered by Medibank. The Kings encountered no problems in accessing the relevant information, or in finding a doctor to perform the operation at a local clinic. Jacqui had considered tubal ligation, however:

My partner was concerned about possible painful side effects of a tubal ligation. He felt I had already suffered enough with difficult pregnancies and painful childbirth, as well as a severe menstrual pain when younger. He understood tubal ligation to be a more complex procedure than vasectomy... [we] felt that vasectomy was a logical, sensible, practical thing to do and [we] felt completely comfortable and confident with the decision.55

Jacqui perceived Daniel’s vasectomy as a protective gesture, which was emphasised by her belief that ‘There was some negativity and resistance from males that vasectomy would result in a loss of manhood and sexual performance’. When questioned about what she felt the biggest change throughout the twentieth century in relation to social attitudes regarding contraceptive sterilisation was, she answered that ‘Concern about loss of sexual performance is not as prevalent in the late twentieth century.’ As has been demonstrated throughout previous chapters, the theme of castration anxiety characterised the history of contraceptive vasectomy, even as the procedure became increasingly popular.56

King and her partner experienced sterilisation during the peak of its contraceptive popularity: they never questioned the legality or morality of the procedure, nor its appropriateness as a contraceptive. Unlike older generations of Australians, the entire process was straightforward and their experience is symbolic of many satisfied couples of this era.

However, there were exceptions to this trend and in spite of the newfound contraceptive success of vasectomy there were people who continued to have difficulty accessing the procedure well into the 1970s. For example, Hank Greggory struggled unsuccessfully to obtain a vasectomy for several years until he found Dr Errey in 1978. Greggory was twenty-three and had a strong desire to be sterilised. His local urologist was unsympathetic and required him to visit a psychologist several times before he would consider performing the operation: the psychologist found him to be ‘a rather emotionally detached, cold blooded fellow’, because he expressed no desire to enter into parenthood and the urologist denied his sterilisation request. In a final attempt to acquire a vasectomy, Greggory sent the following letter to Errey in June 1978:

Dear Doctor Errey,

I have been referred to you by Mrs — of the Townsville Family Planning Association for the purpose of obtaining a vasectomy.

My name is Hank Greggory; I am 23 years old, sell computers for — Ltd in Townsville; am single and childless and have been unsuccessfully seeking a vasectomy since mid-1976. The three major factors that have so far prohibited my obtaining a vasectomy are my age, marital status and parental status.

For the past four years I have been involved in a rather permanent relationship with a young lady. We went through university together; I came out with a B.A. in Mathematics and Computer Programming and proceeded to sell and

57 Letter from Hank Greggory’s* Townsville psychologist to his Townsville urologist, 8 June 1977, BEPC.
program computers, while she came out with a B.A–B.Ed (Hons) and is now working on a Ph.D. Our sex life is good, if sporadic, and only marred by the problems of contraception. We have used the major methods; the pill, condoms and spermicides and so far have been successful but rather disappointed with the day to day problems of such methods.

After a great deal of thought, we came to the conclusion that neither of us want children at any stage of our lives, and so what we needed was a relatively easy, once-only, but extremely permanent method of contraception. Two methods came at once to mind, vasectomy and tubal ligation. Tubal ligation was promptly squashed by the sheer weight of prejudice against a woman who does not want children, and as I wanted an active part in our contraception, we decided on a vasectomy.

After reading several books on the subject and talking to people who had had vasectomies, I decided to act. I approached the Family Planning Association about the subject and have received a great deal of help from them, I have included a resume of my activities in trying to obtain my vasectomy, as well as copies of a psychiatrist’s notes on my ability to make such a decision. After July 1977 I gave up in frustrated disgust and decide to wait a while before trying again. Mrs — contacted me recently, mentioning you, and suggested I contact you.

After teaching mathematics part-time in two of Townsville’s largest schools, tutoring mathematics for four years, having been a play supervisor at the Townsville branch of the Queensland Playground and Recreation Association and spending a lot of time with my relatives’ children, I just feel I have had a lot of experience with them. I like them, but don’t want them. My reasons are simple. They cost a lot of money. They take up a great amount of time. They are dependant for a long period of time. They restrict ones activities. There are a great many problems and frustrations in their upbringing. They are incompatible with my career. I feel that in my case the problems of child-rearing outweigh the pleasures to be gained.

In all my conversations with surgeons, doctors, and friends, so far several common objections have been raised. What happens if you later change your
mind? What will you do without children in your old age? What if you find a new partner who wants children? All these questions have been frequently asked and all have, to my mind, been successfully rebutted. I acknowledge and accept that they are all possibilities but not probabilities. If in the future I want children, there are ways and means of going about it.

After this brief history and explanation of why I desire a vasectomy, I ask you to consider the operation, and advise me if you are willing to perform it. I would be able to fly to Brisbane at any time for a number of days if necessary, and the sooner the better. Could you please advise me as to the approximate cost of the operation and its status with Medibank?

Hope you will be able to help me,

Yours sincerely,

Hank Greggory⁵⁸

This letter is unique as men did but rarely express their thoughts and feelings on vasectomy in such detail. The length of this letter and the extent of the intimate details that Greggory provided reveals that his experience was uncharacteristic of the era: in a context where most couples felt that the decision to undergo sterilisation was entirely their own, the medical profession had continued to control Greggory’s decision. His young age, his lack of children and his single status worked against him in a way that was more representative of the 1940s than the 1970s, and despite being able to justify his desire, he continued to meet with resistance. It was not uncommon for younger people to come up against such attitudes if they desired sterilisation and Greggory’s experience draws attention to the unavoidable role that the medical profession played in access to surgical contraception – regardless of its popularity, a certain level of doctor/patient negotiation would always characterise access to the procedure. This medical authority was challenged in the 1970s with the rise of the women’s liberation movement, however as demonstrated

⁵⁸ Letter from Hank Greggory⁵⁸ to Bruce Errey, 20 June 1978, BEPC.
in Gregory’s letter, ‘the sheer weight of prejudice against a woman who does not want children’ continued to act as a barrier to access. In making a case for his sterilisation, Gregory’s letter emphasises the impact that the simple procedure of vasectomy had on the lives of those who sought it: regardless of the lengths people went to in order to access sterilisation, for those who sought it voluntarily, this surgery was life changing in terms of the accompanying sense of relief it brought – and this was true of vasectomy experiences throughout the twentieth century, not just within the confines of 1970s ‘vasectomania’.

**Laparoscopic Tubal Ligation**

Tubal ligation did not encounter the same media hype or ‘mania’ that vasectomy experienced in the 1970s: female sterilisation was deemed less exciting, it did not have the same connection to population control, or concerns regarding legality that vasectomy did, and the procedure was already an accepted – albeit restricted – element of gynaecological practice. Yet during this period twice as many women than men were sterilised and this remained the case into the late 1980s.\(^{59}\) In 1974, Warren Jones, a senior lecturer in obstetrics and gynaecology at the University of Sydney declared that:

> In Australia, sterilization is gaining rapid acceptance as an attractive alternative to long-term reversible contraception in couples whose child bearing is complete. The belated but enthusiastic upsurge of interest in the male in this country has been paralleled by the popularization in the female of techniques such as laparoscopic and postpartum sterilization, which compete favourably with vasectomy in terms of safety, acceptability and practicability.\(^{60}\)

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Warren argued that tubal ligation had experienced the same upsurge in popularity as vasectomy due to the introduction of the laparoscope, and believed that female sterilisation could now finally rival vasectomy in terms of its simplicity and minimal inconvenience to the patient. This was a popular opinion among Australian gynaecologists and Ian Stewart remembered that the laparoscope was one of the most significant developments of his career – something that drove his practice of female sterilisation. However none of the patients of tubal ligation from the 1970s and ‘80s interviewed for this project recalled the significance of the laparoscope, and the ease of laparoscopic sterilisation did not feature in any explanation given for undergoing the operation. This contrast between medical and lay experiences is characteristic of contraceptive sterilisation throughout the twentieth century and of the doctor/patient relationship more generally. Reproductive healthcare is a site where the convergence of knowledge and power characterises doctor/patient interactions, in which it is doctors who have the authority to dictate the form of the exchange.

Throughout the twentieth century, the practice of surgical contraception provoked an ongoing struggle between doctor and patient authority when it came to individuals’ access to sterilisation procedures, as each party claimed a unique knowledge – either of their personal reproductive needs and choices, or of the surgical procedures required to realise these choices. By the mid-1970s women had contested this previously undisputed medical authority within the realm of reproductive health, and by the early 1980s women were in a position to request tubal ligation regardless of their age, marital status or parity.

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The significance that the medical community has attributed to the introduction of the laparoscope has created the impression that women’s increasing requests for tubal ligation from the early 1970s onwards were the direct result of this new technology.\(^{64}\) For example, both Jesse Olszynko-Gryn and Ian Dowbiggin have argued that laparoscopic technology had a significant impact on women’s decision to undergo tubal ligation.\(^{65}\) However their claims are not supported by evidence from patients who made this choice. Based on a series of interviews with patients of laparoscopic tubal ligation, I argue that the laparoscope had a conscious impact on doctors’ experiences of and attitudes towards sterilisation, not patients’. The advent of laparoscopic technology facilitated increasingly liberal medical attitudes towards female sterilisation, as it made tubal ligation cost effective, time efficient and minimally invasive to the patient. These circumstances were immensely preferable to the traditional laparotomy approach to female sterilisation that was characteristic of the first half of the twentieth century, and in contrast the circumstances of laparoscopy were more conducive to doctors’ engagement with tubal ligation.\(^{66}\) In comparison, women continued to choose sterilisation based on their desire to effectively limit their child bearing capacity: interviewees for this project did not indicate that recovery time or minimally invasive surgery influenced their decision to undergo tubal ligation. The need to be in control of their fertility provided the motivation, while the

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\(^{64}\) See chapter one, ‘The Surgical History of Tubal Ligation’, for a medical account of the impact of laparoscopic technology in the 1970s.


\(^{66}\) Interview with Stefania Siedlecky, 2 September 2013; Interview with Ian Stewart, 26 November 2013; Jaroslav F. Hulka, ‘Teaching Laparoscopy: A Pilot Regional Program in North Carolina’, Contraception vol. 6, no. 2 (1972), p. 152.
laparoscope simply provided the opportunity: this difference between motivation and opportunity is frequently overlooked, and it reveals the absence of patient experiences in existing narratives of sterilisation in favour of medical opinion. In the same way that rates of vasectomy corresponded to ease of access, the increased prevalence of tubal ligation in the 1970s was the medical acknowledgment of the public demand for female sterilisation, not a symbol of women’s newfound desire for the operation based on advances in technology.

Ian Stewart is a prime example of the difference between doctors’ and patients’ experiences of laparoscopic technology. He attributed great significance to the laparoscope – it provided him with a new and impressive skill set early in his career, and a sense of pride and privilege at being among the first in Australia to access and become proficient in this technology:

**Ian Stewart:** This is a moment to just talk about the laparoscope I think, because we [King George V Memorial Hospital in Sydney] were amongst the first hospital to actually look at the laparoscope. Stenning Sinclair, who had imported Wolf Equipment, were very keen to establish it and came up to the hospital – Rodney Shearman invited them up and we had some demonstrations. Demonstrations of laparoscopes on people, probably people with fertility problems – easy just to have a look and see what was going on. And I worked for both of these people, so I actually did a couple of laparoscopies in 1969. We didn’t acquire their equipment for a while, but just before I left [in 1971] they actually got a laparoscope.

Because taking pictures you used to have to eye ball them, there were no screens – that sort of technology was nowhere near available – so only the person holding the telescope could actually see what was going on. Or you could attach a camera to the top and somehow or another there’d be a lead and somebody would press the button over there and take a photograph, and that was very cumbersome.
When I went to England [in 1972], they had already begun to use the laparoscope quite extensively at the hospital I was working at in the north of England in Bradford Yorkshire, and they taught me to do sterilisations there. So when I came back [in 1974], I came back with quite a lot of laparoscopic experience and what we were doing was to actually burn the tube [cauterisation], almost take a piece out…

Stewart emphasised the importance of being among the first to apply this technology, the prestige of working in hospitals that used this new and elusive device, and the advantageous position that this training put him in upon return to Australia in 1974. From a surgical perspective, the laparoscope added a certain amount of glamour to female sterilisation: although vasectomy captured media attention in the 1970s, laparoscopic sterilisation similarly captured medical attention. In 1974, Michael Simcock – gynaecologist and husband of Barbara Simcock – felt that the medical profession had been swept up in the excitement of laparoscopy, to the point where fascination was clouding the judgment of many colleagues: ‘Laparoscopic sterilization is much in vogue, but it should be more widely realized that short-stay sterilizations can be performed with less expensive equipment than the laparoscope [i.e. vaginal sterilization via posterior colpotomy].

Simcock’s words were not heeded, and laparoscopic sterilisation only continued to gain momentum in the medical community. Shortly after his return to Australia, Stewart began work in Wagga Wagga, a rural area of NSW. He recalled that a laparoscope was purchased specifically to persuade him to accept the position on a long-term basis – a highly flattering gesture:

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67 Interview with Ian Stewart, 26 November 2013.
68 A survey of the Medical Journal of Australia from 1970-79 reveals significantly different content regarding tubal ligation and vasectomy: the laparoscope was attributed great significance and was the subject of much technical discussion, whereas vasectomy was mentioned approximately 60% less frequently and discussion tended to focus on the legality of the procedure, rather than any preoccupation with surgical technique.
**Stewart:** I brought the idea of laparoscopy along and I think they must have thought: “well we’ll buy this fella this equipment because we want to keep him, we don’t want him to go anywhere else, we need his services”, and so the laparoscope was acquired and we started to do sterilisations.70

In contrast to the professional status and relative prestige that the laparoscope brought Stewart, patients of tubal ligation in this context were rarely privy to enough surgical information to be consciously aware that the laparoscope had had an impact on their experience – let alone for it to have significantly influenced their overall decision to seek permanent contraception due to the closed nature of medical knowledge in the 1970s.

Although doctors recall that laparoscopy was the most significant development in female sterilisation of the twentieth century, they rarely chose to share this information with their patients, instead telling them only ‘as much as they need[ed] to know’.71 Therefore it is unlikely that the women requesting tubal ligation were doing so in order to reap the benefits of an intriguing new surgical device. Of the women interviewed for this project, Jessica Henson was an exception, as she was the only respondent to be fully informed of the surgical details prior to her sterilisation – she even chose the method of ligation used, opting for Filshie clips. Henson underwent tubal ligation in 1982 at thirty-eight years of age after experiencing difficulties using all other forms of conventional birth control. As an employee of Family Planning QLD, she had extensive experience in reproductive health and remembered that she felt more comfortable with the operation having been fully aware of the surgical details: yet this level of knowledge was not something she thought to extend to her own patients.72 A 1979 pamphlet on contraceptive sterilisation that was distributed by Australian Family Planning clinics demonstrates the

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70 Interview with Ian Stewart, 26 November 2013.
71 Interview with Barbara Simcock, 24 July 2013.
72 Interview with Jessica Henson*, 14 January 2014.
limited information that the average patient received when researching tubal ligation prior to surgery:

Sterilization for Women – Tubal Ligation

Q: What does the doctor do?
A: Through a small abdominal incision, he cuts and ties the small tubes through which the ovum (egg) passes to the uterus each month. This prevents the union of the man’s sperm and the woman’s egg and there can be no pregnancy. This operation can be done through a very small abdominal incision with a narrow instrument called a laparoscope.

Q: What happens to the egg?
A: The tiny ovum is harmlessly absorbed in the body.

Q: How do doctors rate this operation?
A: It is just as effective as vasectomy and it quite a simple operation. However the need to open the abdomen means that the patient requires to stay in hospital for about three days. Laparoscopic sterilization enables the patient to go home on the day after operation.73

This excerpt represents two thirds of the information that patients received: no further detail regarding surgical technique or practice was provided – Norman Haire offered more surgical detail in Woman magazine in the 1940s.74 Though laparoscopic technology was mentioned, the significance of this technology was not made apparent to the reader: laparotomy was vaguely referenced, yet the pamphlet did not clearly outline how this was different to laparoscopy or why tubal ligation was now considered to be ‘quite a simple operation’. In 1982 postgraduate student Maureen Frances surveyed twenty-five couples who had recently undergone contraceptive sterilisation, her results revealing that several

73 ‘Sterilization’, pamphlet created by The Family Planning Association of the Northern Territory, (1979).
74 See Figure 4.4; Wykeham Terriss, ‘A Doctor Looks at Life – Sterilisation Queries’, Woman, 23 April 1945, Box no. 2.25 (2), Norman Haire Collection, University of Sydney Rare Books Collection [hereafter NHC].
factors contributed to a couple’s choice between male and female sterilisation – of these factors, technology did not rate highly. Although several couples in the study opted for vasectomy because it was less invasive, this was outweighed by a psychological aversion to vasectomy, and no couple listed developments in technology as their reason for choosing tubal ligation.75 Although the introduction of laparoscopic tubal ligation was one of the most significant medical developments in the history of female sterilisation, it would be a mistake to assume that this technology had the same impact on lay women as it did on doctors, as these two groups had a fundamentally different relationship to sterilisation: but if laparoscopic tubal ligation did not characterise women’s experiences of sterilisation in the 1970s and ‘80s, then what did?

75 Frances, ‘Choice of Contraceptive Sterilisation’, p. 72.
STERILIZATION FOR WOMEN — TUBAL LIGATION

Q. What does the doctor do?
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Q. Is the operation painful?
A. No because a general anaesthetic is used but there is some abdominal soreness for a few days after operation.

Q. Will it interfere with sexual interest and enjoyment?
A. No. The operation has no direct effect on sexual intercourse. Most women find love-making more interesting and enjoyable when the fear of an unwanted pregnancy is removed.

Q. Will menstruation be altered?
A. No. Ovulation and menstruation will continue as before and the menopause (“change of life”) will not occur earlier than usual.

Q. Could the operation impair femininity?
A. Not at all. Female attractiveness continues as before and is determined by ovarian hormones which are produced as usual.

Q. Is there a preferred time for sterilization?
A. Tubal ligation can be done at any time when a couple are certain that they do not want any more children. The operation may be performed soon after confinement so that the woman does not have to return to hospital at a later date.

Q. Will there by any need to use contraception for a while after operation?
A. No.

Q. What do our laws say?
A. Tubal ligation is legal.

Q. How is the operation arranged?
A. By seeking advice from your local doctor or from a Family Planning Clinic.

Q. What does a tubal ligation cost?
A. As long as the common fee is charged, an insured patient will recover the cost of the operation, all but a few dollars, in medical rebates.

The Family Planning Association of the Northern Territory (1979).

If you have any other questions you would like to ask, write in confidence to The Family Planning Association of N.T. P.O. Box 3158, Darwin. Telephone 815335
There were many reasons why women chose tubal ligation as opposed to vasectomy in this context: if male partners were uncomfortable with vasectomy and believed that contraception was a female responsibility; if the woman had experienced gynaecological problems or difficulties using other contraceptives; or if she had a desire to have no more children and to be in complete control of her fertility. Maureen Frances’ 1982 survey found that couples who chose tubal ligation were more likely to be less educated and of a lower-socio economic status than couples who chose vasectomy: the reason for this being that better educated men were less likely to be restricted by feelings of anxiety regarding vasectomy as they could see that vasectomy was the less invasive, and subsequently more logical procedure.\textsuperscript{76} It was this discrepancy that motivated Frances’ study – she set out to determine why tubal ligation was more popular than vasectomy when male sterilisation was more cost effective, time efficient, and less invasive.\textsuperscript{77} Returning to the experience of Deborah Fielding, a committed Catholic woman who underwent tubal ligation in 1972, demonstrates the attitudes reflected in Frances’ study. Fielding experienced significant internal conflict as a result of the Church ban on contraception and her need for reliable birth control. In contrast, her Catholic husband had no moral objections to contraception, yet would not consider a vasectomy in place of Fielding’s use of the pill and eventual sterilisation.

\textbf{Tiarne Barratt:} You mentioned that your husband wouldn’t get a vasectomy, was that because he had religious objections to sterilisation, or he just didn’t want the operation?

\textbf{Deborah Fielding:} He thought he mightn’t – it might affect him! You see, he didn’t have the confidence enough to even go and talk about it to somebody.

\textsuperscript{76} Frances, ‘Choice of Contraceptive Sterilisation’, pp. 90-1.

\textsuperscript{77} Frances, ‘Choice of Contraceptive Sterilisation’, pp. 1-2.
Oh no – it’s almost as if, “you have the children, you do something about it”. Took no responsibility at all.

TB: So did he have a problem with you having your tubes tied?

DF: No, in fact, quite the opposite I suppose when you think about it. There’s no more, “No not tonight Josephine” you see. I mean, that’s just my husband, but I think a lot were like that.78

Both Fielding and her husband originally came from low-socio economic situations, recalling childhood money struggles in the context of war and Depression, which were then reflected in their final contraceptive decision. Fielding’s husband was minimally involved in her decision to undergo tubal ligation, which Frances’ study indicated was typical of the context and circumstances: her study found that a fear of vasectomy, lack of interest in contraceptive decisions, and the belief that contraception was a female responsibility went hand in hand in partners of women who had recently been sterilised.79

Vasectomy was considered to be the more progressive option and Fielding felt a great sense of pride decades later when her sons chose to undergo sterilisation in place of their wives.80 Of course, not all experiences of sterilisation subscribed to these circumstances, as many women actively desired tubal ligation rather than vasectomy due to the reproductive control and freedom that it provided. The introduction of the pill had significantly altered gendered understandings of contraceptive responsibility in the second half of the twentieth century, as amongst other things, its uptake normalised women’s participation in the public realm of birth control and diminished male contraceptive responsibility.81

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78 Interview with Deborah Fielding*, 23 April 2014.
80 Interview with Deborah Fielding*, 23 April 2014.
81 Although further research on the shift of gendered contraceptive responsibility in the middle of the twentieth century is required, it is indicated that the uptake of the pill played a significant role in this phenomenon; Kate Fisher, Birth Control, Sex, and Marriage in Britain 1918-1960 (Oxford: Oxford University Press, 2006), pp. 241-2; Hera Cook, The Long Sexual Revolution: English Women, Sex and Contraception, 1800-1975 (Oxford: Oxford University Press, 2004), pp. 268-70; Lisa Featherstone, Let’s
The pill had a significant impact on the uptake of contraceptive sterilisation in the 1970s, albeit indirectly. Whether women had been satisfied users and chose to replace oral contraceptives with a long-term method after the completion of their families, or whether they had been dissatisfied users and sought a more effective method with less side effects: either way, the introduction of the pill meant that women felt more entitled to effective contraception than previously, and subsequently felt more entitled to tubal ligation.82

Wendy Simmons was a satisfied pill user when she came to consider sterilisation in 1976: born 1944, oral contraceptives had been available to her for the entirety of her reproductive life and she had successfully used the pill since her early twenties. After two children, Simmons felt that her family was complete and sought a more permanent contraceptive solution: ‘My husband and I made a mutual decision that it should be me. I didn’t care which of us was sterilised but he certainly wasn’t keen for it to be him! Not sure if he was just squeamish or felt it may affect his sex drive, but he definitely wasn’t keen.’83 Male friends had regaled him with stories of the pain of vasectomy and Simmons decided to pursue tubal ligation instead, a decision that she remained happy with decades after the operation. Simmons remembered that in the mid-1970s, contraceptive sterilisation was widely discussed: she knew of friends, relatives, colleagues who had undergone the procedure, all of whom were happy with their decision – it seemed the obvious route to take after deciding upon no more children. In contrast, Jessica Henson, also born in 1944, was a dissatisfied pill user and this equally fuelled her decision to undergo tubal ligation.

Like Simmons, Henson was part of the first generation of women to have had relatively unrestricted, socially accepted access to reliable contraception. However unlike Simmons,

83 Interview with Wendy Simmons*, 8 August 2013; Wilson, ‘Female Sterilization by the Laparoscope in Smaller Suburban Hospitals in Sydney’, p. 893.
Henson was unable to use the pill due to medical side effects and had spent much of her reproductive life struggling with her fertility on various different methods of birth control. After two children, Henson was ‘quite clear’ that she did not want any further pregnancies and wished to be permanently free of such anxieties, regardless of her future relationship status. It was this certainty in her desire for sterility that led to her choice of tubal ligation over vasectomy: with the knowledge that she could not use conventional contraceptives, she desired the finality of tubal ligation. Having been surrounded by a culture of oral contraception, neither woman questioned her right to access contraceptive sterilisation.

Margaret Weber was born in Britain in 1945 and in 1971 she and her husband migrated to Perth, Western Australia. Shortly after their arrival, her husband found work in a nearby country town, where he left Weber alone with two young children – the second pregnancy unplanned. She quickly sought contraceptive sterilisation.

**Margaret Weber:** I was alone most of the time with two babies and was lonely, very tired and bored. I became convinced that if this was the price I had to pay to become a mother, then the price was too high and I was determined to have no more children.85

Weber’s dissatisfaction with life confined to the home casts back to the 1950s, when the feminine homemaker identity was held up as the ideal state of marital happiness and financial security – this was a source of significant internal confusion for many who were deeply unsatisfied with this way of life, and similarly Weber did not expect her circumstances to cause such unhappiness.86 Despite her willingness to undergo tubal ligation upon the realisation that she did not enjoy motherhood, Weber’s husband instead

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84 Interview with Jessica Henson*, 14 January 2014.
85 Interview with Margaret Weber*, 26 June 2014.
insisted on undergoing vasectomy in 1972. Initially she thought that the vasectomy was him ‘making a supreme sacrifice for us as a family’, which again had roots in 1950s understandings of ideal domesticity. Yet Weber soon discovered that her husband had elected to undergo vasectomy ‘because he was having lots of affairs around town, affairs I did not know about’. The marriage disintegrated shortly after this revelation and Weber moved back to Perth, where the urban setting gave her access to a wider array of healthcare options and she opted to undergo sterilisation in 1975:

**MW:** After separation from my first husband, I became sexually active with different partners so decided to have a tubal ligation. I was very adamant I did not want any more children and when I met my second husband he also did not want children. I insisted on going ahead with the tubal ligation just in case the new relationship did not last. I also wanted to feel in complete control of my fertility and not leave anything to chance.  

This statement reveals that like Henson, Weber did not wish to leave the question of her fertility to chance and was prepared to undergo tubal ligation regardless of the circumstances. Although the uptake of laparoscopic sterilisation meant that she experienced a straightforward operation and a timely recovery, this was not what motivated her decision, as the idea of laparotomy was equally palatable to her. Weber had heard tubal ligation advertised on a radio programme discussing her local women’s health centre and access was as simple as calling the number provided to make an appointment. Unlike the women who underwent sterilisation in earlier decades, she was not required to justify her actions – with the aid of women’s health activism, a desire to have no more children came to be considered a valid reason to undergo contraceptive sterilisation surgery.  

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87 Interview with Margaret Weber*, 26 June 2014.  
As the 1970s flowed into the 1980s, rates of tubal ligation remained steady and contraceptive sterilisation had become, in the eyes of many, a completely normalised method of birth control: the only aspect to remain controversial was the question of spousal consent. Spousal consent referred to the practice that many doctors employed, of requiring both husband and wife to sign a consent form prior to the sterilisation procedure, regardless of whether it was tubal ligation or vasectomy that was to be performed. Into the 1980s – and perhaps longer in some circumstances – there was a longstanding belief that spousal consent was necessary in order to minimise the chance of postoperative litigation occurring. This belief began with Australia’s earliest practitioners of contraceptive sterilisation and was fuelled by British reports in the 1960s and ‘70s of disgruntled spouses who had been unaware of their partner’s decision to undergo sterilisation prior to the operation and took legal action against the operating doctor accordingly.89

A husband has an interest in his wife’s fertility. A wife has an interest in her husband’s fertility and has legal rights in the matter… I always get a written statement, signed by both husband and wife, saying that they understand the nature of the operation of vasectomy, that it confers permanent sterility.90

– V.H. Wallace

Like much of this history, there was no unified or regulated policy concerning spousal consent and individual doctors could enforce this practice in whatever way they saw fit – indeed the question of spousal consent only came to light through a series of oral history interviews, apart from which there are few written traces of this phenomenon. Each doctor interviewed for this project required spousal consent prior to operation at the beginning of

their career, before coming to individual realisations that this practice was unnecessary, restrictive, and in many cases, insulting to the patient:

**Barbara Simcock:** And after a while I said this is ridiculous. So in the end they [Family Planning NSW] dropped the male consent for the woman. After all, if you have your appendix out, you don’t expect your husband to give consent, it’s your body, and it’s your appendix.91

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**Ian Stewart:** …early on, were expected to get the husband to sign his approval [prior to tubal ligation]. But we soon found that that was not only unnecessary, but it was also very demeaning and I thought, no, no we don’t need to do this.

**Tiarne Barratt:** So is that something you just decided to stop doing?

**IS:** We had to speak to the hospital about it, because they seemed to have a form – you had to fill out a form and if you didn’t fill out the form then maybe you shouldn’t be doing this – and eventually we got them to eliminate that.

In addition, double standards were applied to spousal consent regarding male and female sterilisation, as doctors were far more likely to waive the need for a wife’s consent for vasectomy, rather than a husband’s consent for tubal ligation: for example Bruce Errey recalled sterilising a man in secret from his Catholic wife – his patient card noting that ‘no mail be sent to this address’.92 In the midst of the feminist health movement of the 1970s and ‘80s, this practice outraged Noreen Collins when she sought tubal ligation in 1983.

Born in 1953 and raised in a country town in rural Queensland, at thirty-two years of age Collins decided that her two children were all she wanted and arranged a tubal ligation procedure through her local doctor:

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91 Interview with Barbara Simcock, 24 July 2013.
92 Interview with Bruce Errey, 15 January 2014.
Noreen Collins: I had no problems [accessing the operation] BUT I had a major problem that I could not have the operation unless my husband provided written consent. Had he had a vasectomy, I would not have been required to give my consent.93

Although doctors went to great efforts to ensure that men were not coerced into vasectomy by their wives – popular medical opinion was extremely concerned with the adverse psychological side effects associated with involuntary vasectomy – such practices did not extend to women undergoing tubal ligation at their husband’s request.94 Though this was not the typical experience of female sterilisation, there were women who underwent sterilisation at the insistence of their husbands. For example interview participant Carolyn Flynn, who was sterilised in 1982, only to have the procedure reversed several years later upon divorcing her husband:

Tiarne Barratt: Why did you have the operation instead of your partner?

Carolyn Flynn: He made me. My husband made me have it.95

Flynn was the only respondent in this study to express anything other than complete satisfaction with her sterilisation, because she was the only one who was uncomfortable with the decision to begin with. This experience was uncharacteristic of the era, as the vast majority of patients were extremely happy with the reproductive freedom that tubal ligation afforded them, particularly once spousal consent, or even the absence of a husband, ceased to act as a barrier to access.

93 Interview with Noreen Collins*, written response to ‘Experiences of Tubal Ligation and Vasectomy in Australia’, 8 October 2014.
95 Interview with Carolyn Flynn*, written response to ‘Experiences of Tubal Ligation and Vasectomy in Australia’, 7 September 2014.
In 1986, the combination of tubal ligation and vasectomy accounted for thirty-eight per cent of birth control usage among Australian women aged 20-49. Sterilisation was at the peak of its contraceptive success, a popularity that was unique to the 1980s.\textsuperscript{96} Janet Madison’s experience of tubal ligation in 1985 is symbolic of contraceptive sterilisation during this period of unsurpassed popularity. She recalled that sterilisation was a widely used and widely discussed method of birth control amongst her friends and colleagues:

\textbf{Janet Madison:} It seems to me that it was a fairly common topic of conversation when you were working, that a workmate would either be going to have a vasectomy or have their tubes tied when they had finished having their family. I never found it to be a topic that was avoided. It just seemed to be “out there” in common use.\textsuperscript{97}

Madison was a divorced working mother with a three year old son. She was thirty years old at the time of her sterilisation, with no future plans to marry. Instead she desired tubal ligation in order to date freely without the anxiety of unplanned pregnancy materialising – she was unapologetic about her desire to engage in worry-free sex for the remainder of her reproductive life: ‘I wanted to make sure that I would not fall pregnant and [tubal ligation] was the appropriate way to achieve that’. The circumstances surrounding Madison’s tubal ligation reveal the level of normalisation that contraceptive sterilisation had achieved by the mid-1980s: in 1970 the \textit{British Medical Journal} had declared that sterilisation in order to ‘enable a man to have the pleasure of sexual intercourse without shouldering the responsibilities attaching to it, is illegal.’\textsuperscript{98} Fifteen years later, it was possible for a \textit{woman} to request sterilisation for this express purpose, and Madison had no difficulty accessing


\textsuperscript{97} Interview with Janet Madison*, 4 April 2014.

\textsuperscript{98} ‘Legality of Sterilization’ [1970], p. 704.
the procedure: ‘The operation was not a problem at all. I just felt complete relief after I had it done and knew I didn’t have to worry about pregnancy and that I had done the right thing by myself and looked after my own body.’ Madison’s satisfaction with her decision to undergo tubal ligation and the sexual freedom that it provided her was characteristic of the mid-1980s. As these patient interviews have revealed, in the majority of circumstances contraceptive sterilisation became increasingly accessible as the twentieth century progressed: yet what did not alter significantly was the overarching reason for which people sought sterilisation. Although rates of tubal ligation and vasectomy were influenced by changing social, medical, legal and political contexts throughout the century, underneath this was an unwavering desire for individual reproductive control that was so powerful that it eventually propelled sterilisation to the new heights of popularity it achieved in the 1980s.

**Conclusion**

Through showcasing patient case studies of tubal ligation and vasectomy, this chapter has demonstrated the frequently overlooked distinction between doctor and patient experiences of contraceptive sterilisation. Doctors, the gatekeepers of surgical contraception, were strongly influenced by developments in technology, the legal ambiguity of sterilisation, and the attitudes of the broader medical community. By contrast, patients of these procedures were largely influenced by a desire to control their own fertility in a way that would contribute positively to their lives and personal relationships. The amalgamation of these experiences led to the widespread availability of contraceptive sterilisation witnessed in the 1970s and ‘80s. During this period of popularity, for the most part patients were completely satisfied with their experience of sterilisation, and in contrast to earlier in the

99 Interview with Janet Madison*, 4 April 2014.
twentieth century, doctors were required to facilitate access to sterilisation lest they lose favour with their clientele. By the mid-1980s sterilisation had become such an embedded, normalised, and characterising feature of the Australian contraceptive landscape that it was no longer the subject of extensive media or medical attention: now accepted, uncontroversial, and at the height of technological success, there was no need for a continuation of this public discussion. However, by the mid-1990s, the contraceptive landscape had been once again transformed and sterilisation was no longer the focus of the attention or public demand it had once been. In 1995, although rates of vasectomy had remained steady, rates of tubal ligation had decreased by approximately fifty per cent of what they were in 1986.\textsuperscript{100} In addition, the overall percentage of women using any method of birth control had fallen from seventy-six per cent of women surveyed in 1986, to sixty-sixty per cent of women surveyed in 1995. Instead of continuing on the upward trajectory of contraceptive success that sterilisation had been on since the 1940s, public attention reverted to coercive practices and the sterilisation of people with disabilities, particularly female children.\textsuperscript{101}

Doctors had continued to sterilise people with disabilities, some of them children, upon request throughout the twentieth century, yet in the early 1990s this practice became a public issue, characterised in Australian history by “Marion’s Case” in 1992.\textsuperscript{102} “Marion” was a fourteen year old girl with intellectual disabilities, severe deafness and


epilepsy, whose parents sought a court order for her sterilisation: within this case the issue arose of who had the legal authority to authorise Marion’s sterilisation; her parents, the court, or Marion herself? The High Court of Australia ruled that parents did not have the authority to consent to the sterilisation of their children – only the court could consent to such an action. The history of contraceptive sterilisation was overshadowed by public support for eugenic sterilisation in the first half of the twentieth century: this was then replaced with public outrage over the sterilisation of people with disabilities in the second half of the twentieth century, and the contraceptive success of the 1970s and ‘80s soon became similarly overlooked. This chapter concludes in 1986, because this was the high point in the contraceptive application of sterilisation, a rare point in time when sterilisation was openly discussed without any association with eugenics or coercion. The experiences of contraceptive sterilisation from the 1970s and ‘80s showcased here add a personal element to a narrative that is often considered on a much larger, more impersonal scale. These individuals’ experiences were not representative of the phenomenon of sterilisation overall, but rather they reveal the various ways in which tubal ligation and vasectomy have had an impact on thousands of people’s lives throughout the twentieth century. For many, the experience of sterilisation was life changing, whether the operation took place under voluntary or involuntary circumstances, yet for the most part, those experiences will remain anonymous statistics – this chapter was an opportunity to share some of those stories and demonstrate the impact of contraceptive sterilisation on the lives of everyday Australians.
Conclusion

The popularity of contraceptive sterilisation in twentieth century Australia was characterised by a diachronic rise to success that occurred over the course of several decades. Although contraceptive surgery was performed in the early twentieth century, it was not until the 1950s that tubal ligation and vasectomy were publicly discussed as contraceptives, and the widespread availability of these procedures reached its zenith in the mid-1980s. Much of this success was dependent upon the socio-political context in which it occurred. In the mid-twentieth century, standards of heteronormativity began to emphasise the importance of mutual sexual pleasure and companionship within marriage, both of which were hindered by fears of unplanned pregnancy and socio-medical attitudes towards sex and reproduction became accordingly accommodating of surgical contraception.¹ This was followed by a move towards the separation of sex and reproduction during the “sexual revolution” of the 1960s, which coincided with the introduction of the pill and a shift in perceived contraceptive responsibility: contraception was increasingly constructed as a woman’s responsibility, and women became progressively more involved in public discussion of sex and reproduction.² Women’s public participation and increased confidence in regards to sexual health was then amplified in the context of the women’s liberation movement, and more specifically the women’s health movement – which in Australia, was focussed on women’s increased access to reproductive health care services. These developments corresponded with an international awareness of population growth, and global concerns regarding the issue of

overpopulation. In this context, sterilisation procedures were the subject of significant media attention, and by the mid-1970s the public demand for contraceptive sterilisation had become so great that this service was readily available throughout most of Australia.

Eugenic and involuntary practices of sterilisation have often overshadowed the widespread contraceptive application of these surgical procedures, therefore one of the central aims of this thesis was to demonstrate that the history of sterilisation represents a significant aspect in the history of birth control. Throughout the twentieth century voluntary sterilisation was far more prevalent than involuntary sterilisation, however the stringent belief that sterilisation was eugenic in the first half of the twentieth century has masked the presence of contraceptive sterilisation in this period.3 Because tubal ligation and vasectomy are typically considered first and foremost involuntary measures, this has eclipsed the voluntary capacity of this surgical technology. This history was then further obscured by the introduction of the pill, as subsequent historical consideration concentrated on the impact of oral contraception in the second half of the twentieth century: this was typically with a focus on individuals in their twenties rather than older demographic groups.4 Further, when sterilisation was enjoying the height of its contraceptive popularity, coercive sterilisation – already taboo due to associations with the holocaust and genocide – once again captured public attention in the 1990s: the sterilisation of minors with disabilities became a hotly debated issue and this was encapsulated by Marion’s Case in Australian history.5 Therefore the history of

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5 Department of Health and Community Services v JWB and SMB (Marion’s Case) [1992] HCA 15, 175 CLR 218, (6 May 1992), High Court of Australia,
contraceptive sterilisation is book-ended by public discussion of eugenic and coercive sterilisation, the influence of which has been extensive. The impact of contraceptive sterilisation is parallel to that of the pill, yet discussion is confined to the early decades of the twentieth century and legal debates of the 1990s. This thesis is an attempt to rectify this historiographical positioning of tubal ligation and vasectomy procedures and to broaden the scope of the history of contraception more generally.

Throughout this thesis, male and female sterilisation have been considered side by side, an infrequent occurrence within histories of birth control, in which women are often the primary focus. There is no question that women’s experiences of birth control are central to this history, or that contraceptive responsibility has been heavily gendered in this way since the 1960s, however the inclusion of men and masculinity in this narrative is beneficial, indeed historically necessary. Birth control consists of a series of gendered interactions, therefore historical consideration of this phenomenon should account for the reality of shared male and female experience. As has been demonstrated throughout this thesis, men had significant involvement in contraception via vasectomy throughout the twentieth century, which was often characterised by a desire to protect and provide in accordance with contemporary expectations of masculinity. Additionally, contraception was a shared experience for many couples in the second half of the twentieth century and the growing importance attributed to mutual sexual satisfaction and the increasing acceptance of female sexuality are both further illuminated by the acknowledgment of male involvement in the history of contraception. This is because female sexual desire – one of the main reasons that women require contraception – is often overlooked when


women’s experiences are viewed in isolation from men’s. Although there are of course a
variety of other reasons why women require effective contraception, a desire to be in
control of one’s fertility in order to pursue sexual relationships characterised experiences
of tubal ligation and vasectomy throughout the twentieth century, and both men and
women often reported that their quality of life had been improved by contraceptive
sterilisation.⁷

Though heavily influenced by the broader socio-political context of the second half
of the twentieth century, the availability of surgical contraception was largely dependent
on a public demand for contraceptive sterilisation. Many individuals sought sterilisation
procedures in order to free themselves from the anxieties created by the potential for
unwanted pregnancy and tubal ligation and vasectomy provided people with a
transformative level of reproductive security – the impact of surgical contraception was far
reaching. The contraceptive success of tubal ligation and vasectomy was akin to that of the
pill, however it was all the more notable because these procedures did not have clear
financial support: for example, the global pharmaceutical industry had a significant interest
in the successful uptake of oral contraceptives, whereas sterilisation was not connected to
any specific industry or company and its availability was largely determined by popular
demand. As oral history interviews and patient records have shown, there was a significant
public demand for reliable and effective surgical contraception that became increasingly
prevalent throughout the twentieth century and one effect of this was that doctors became
more inclined to operate in contraceptive circumstances.

⁷ Interview with Deborah Fielding* by Tiarne Barratt, 23 April 2014; Interview with Greg Hanson*, written
response to ‘Experiences of Tubal Ligation and Vasectomy in Australia’, 21 January 2014; Interview with
Janet Madison*, written response to ‘Experiences of Tubal Ligation and Vasectomy in Australia’, 4 April
2014.
The support of individual medical practitioners and the technology that they had at their disposal was an integral element of the contraceptive success that sterilisation procedures witnessed in the second half of the twentieth century. As tubal ligation technology became safer and more efficient, doctors became more willing to perform contraceptive operations. Similarly new technology such as the laparoscope added an element of clinical prestige to gynaecological surgery that had been absent earlier in the twentieth century.\(^8\) In contrast, male sterilisation technology did not undergo significant development. Instead its success was dependent on media attention that dispelled castration anxiety, and upon doctors’ response to the newfound public demand for vasectomy services.\(^9\) This thesis has demonstrated the significance and influence of individual doctors: the impact that Haire, Wallace, Siedlecky, Errey, Simcock, and Stewart had on the availability of surgical contraception was extensive and oral history interviews with the latter four have brought to light a number of key insights. These doctors represented some of the earliest and most influential providers of contraceptive sterilisation, and the normalisation that tubal ligation and vasectomy experienced would not have been possible if individuals such as themselves had not been willing to meet the ever-increasing public demand for these procedures. However this demand for surgical contraception did not remain consistent after the 1980s and sterilisation is no longer such a dominant force in the Australian contraceptive landscape.

Although public demand played a significant role in facilitating the widespread availability of contraceptive sterilisation, as contraception became an increasingly profitable industry towards the end of the twentieth century, sterilisation procedures began

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\(^8\) Interview with Dr Ian Stewart by Tiarne Barratt, 26 November 2013; Interview with Dr Stefania Siedlecky by Tiarne Barratt, 2 September 2013.

\(^9\) Interview with Dr Bruce Errey by Tiarne Barratt, 15 January 2014; Interview with Dr Barbara Simcock by Tiarne Barratt, 24 July 2013.
to decline in popularity: by the late 1990s new developments in the field of long-acting hormonal birth control had instead become a considerable presence on the contraceptive landscape. While tubal ligation continues to protect more women in the world from unwanted pregnancy than any other method, in Australia female sterilisation now represents only 6.6% of contraceptive use. In contrast, vasectomy has represented approximately 10% of Australian contraceptive use since the mid-1980s and continues to do so because vasectomy has remained easily accessible and relatively inexpensive in the private healthcare sector. Additionally, a lack of innovation has meant that vasectomy and condoms remain the only male contraceptive options available – both of which have contributed to the steady popularity of male sterilisation. In contrast, tubal ligation has become increasingly difficult to access due to the wait periods in the public health care system for elective surgery. Instead female sterilisation has been replaced by the wide variety of Combined Hormonal Contraceptives (CHC) available to women, such as: oral contraceptive pills, the vaginal ring, hormonal injections known as Depo-Provera, etonogestrel implants such as Implanon, hormonal IUD’s (intrauterine devices), and emergency contraception colloquially known as the ‘morning after pill’. Hormonal contraception is one of the only areas of birth control that is the subject on ongoing research and pharmacological innovation in the twenty-first century: it is a multi-billion


A large part of the public demand for contraceptive sterilisation in the 1970s was the result of women’s dissatisfaction with hormonal contraception: for those women who continue to have difficulty using hormonal contraceptives, the options are fewer than they were in the 1980s, as tubal ligation has now become increasingly difficult to access and those considering sterilisation are encouraged to first try long-acting hormonal contraception; Read et al. eds., Contraception, pp. 163, 169.
dollar global industry that is projected to increase in coming years as awareness of CHC grows in developing countries.\textsuperscript{13} Unlike hormonal contraceptives, sterilisation is not supported by the global pharmaceutical industry as it does not have the same capacity for financial profit.\textsuperscript{14} However further research into the declining popularity of contraceptive sterilisation in the twenty-first century is required as this is no doubt as complex as its initial rise to popularity.

Oral history was crucial to understanding the uptake of surgical contraception in Australia. Due to the closed nature of the medical profession, little of this history was ever recorded and much of this information exists only in the memories of those directly involved. A series of oral history interviews with key doctors illuminated the history of contraceptive sterilisation in Australia from a medical viewpoint and demonstrated the difference between doctor and patient experiences of this phenomenon: although doctors were integral to the rise of contraceptive sterilisation, they were considerably motivated by public demand. For this reason, patient experiences of tubal ligation and vasectomy provide a counterpoint to a history typically told through legal, official changes, through the experiences of doctors involved, or through public discussion. While doctors are an integral aspect of this history, the prioritisation of their narrative on behalf of their patients

is not representative of actual patient experiences of these procedures.\textsuperscript{15} When contraceptive sterilisation became readily available in the 1970s, its effect on the lives of every day Australians was extensive: the contrast between historical patient records and oral histories conducted in 2013-14 revealed the extent of the impact that surgical contraception had on many people’s lives. Historical patient records highlighted the importance that people attributed to obtaining contraceptive sterilisation; whereas oral histories revealed that the extent to which people deemed the procedure to be significant decreased over time as they became accustomed to the ongoing benefits of permanent contraception. In contrast to the sense of desperation that frequently characterised patient letters, this fading importance attributed to sterilisation as people aged demonstrates the extent to which contraceptive sterilisation enabled its recipients to live a life free from reproductive concerns. This capacity to effect lasting change on individuals’ reproductive and sexual lives is the reason why sterilisation represents such an important aspect of the history of birth control in the twentieth century, and why this particular history is deserving of further scholarly attention.


SECTION A - Demographic Information:

1. Please state your gender:

2. Please state your date of birth:

3. Please describe your socio-economic background:

4. Please describe your cultural background:

5. What is your country of birth?

6. Is English your primary language?

7. Do you identify as Aboriginal or Torres Strait Islander?

8. What is the highest level of education you have attained?

9. How would you describe your religious beliefs/background?

10. In what year did you/your partner have the sterilisation procedure that is the focus of this survey?

11. What state did you live in at the time of this sterilisation procedure?

SECTION B - Contraceptive Sterilisation:

If you are responding to this questionnaire it is assumed that you used sterilisation as your primary method of birth control at some point from 1960-1985. The following questions relate to your experience with this method of birth control. Please provide as much detail as possible in your response, and feel free to leave any questions blank if the content makes you uncomfortable.

1. Please outline whether it was yourself or your partner who had the sterilisation procedure and what the reasoning behind this choice was.

2. What were the circumstances that led to you choosing sterilisation as your primary method of birth control? I.e. you already had children, you had had an abortion, you had financial concerns, you were unsatisfied with other methods of contraception, etc.
3. How did you find out about sterilisation as a method of contraception and how readily available was this information?

4. What did you have to do to organise the sterilisation procedure and where did you/your partner go to have the procedure? How difficult was this process?

5. How much did the sterilisation procedure cost? Was this considered expensive? I.e. did you have to save up for the procedure?

6. To your knowledge, was sterilisation considered a popular method of contraception at the time of your/your partner’s procedure? I.e. did you know other people who’d had similar procedures, and so on?

7. Were you ever uncertain about the legal status of contraceptive sterilisation? I.e. did you ever feel like the procedure could be illegal? Why/why not?

8. Was your/your partner’s sterilisation procedure something that you discussed with friends or family? I.e. was it considered an appropriate topic of conversation, or was it something you felt you had to keep to yourself?

9. How did your religious beliefs and/or cultural background influence your feelings towards contraceptive sterilisation? Do you think that this was a common attitude?

10. My thesis argues that contraceptive sterilisation became increasingly normalised throughout the second half of the twentieth century: how do you feel about this statement? And how would you explain your opinion towards this statement?

11. Do you have any further comments?

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